100TH CONGRESS
2d Session

SENATE

REPT. 100-291
Volume 1

DEVELOPMENTS IN AGING: 1987
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 80, SEC. 19, JANUARY 28, 1987

Resolution Authorizing a Study of the Problems of the
Aged and Aging

FEBRUARY 29 (legislative day, FEBRUARY 15), 1988.—Ordered to be printed

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U.S. GOVERNMENT PRINTING OFFICE
81-932 WASHINGTON : 1988

S143-1

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, February 29, 1988.

Hon. GEORGE BUSH,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 80, agreed to January 28, 1987, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1987, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1987 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN MELCHER, *Chairman.*

SENATE RESOLUTION 80, SECTION 19, 100TH CONGRESS, 1ST SESSION [1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from March 1, 1987, through February 29, 1988, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,077,424, of which amount (1) not to exceed $33,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $800 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

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[1] Agreed to January 28, 1987.

PREFACE

A number of particularly noteworthy developments in aging emerged in 1987. Topping the list were the passage of separate catastrophic health care bills in both the Senate and House, the 4-year reauthorization of the Older Americans Act, and the housing reauthorization bill. In addition, striking an acceptable balance between the need to reduce the Federal deficit and the desire to address the many unmet social needs of the Nation continued to be the most challenging issue confronting the Congress and advocates for the elderly. Most new initiatives required financing which was either budget neutral or which would actually reduce the deficit. As a result, there was limited progress made toward resolving the many major challenges facing the elderly including: The lack of protection against the devastating costs of long-term illness, the spiraling Medicare Part B program expenditures, and the decline in affordable, adequate housing.

Operating within these forces, the Special Committee on Aging contributed to an impressive record of legislative accomplishments during the first session of the historic 100th Congress. This session saw the passage of watershed legislation to protect the elderly against the costs of acute catastrophic illnesses. By conducting several hearings on the catastrophic health issue and releasing two comprehensive General Accounting Office reports on the subject, the committee was actively involved in efforts leading to passage of the Senate bill. In addition, the Chairman and Ranking Member successfully offered important amendments to the Senate-passed version. The catastrophic health care legislation, which is awaiting final passage, caps the amount a beneficiary must pay out-of-pocket for Medicare-covered services, extends the number of days covered under Medicare's home health and skilled nursing facility benefit, and expands the Medicare Program to cover the costs of prescription drugs once a deductible is met.

Another one of the more significant pieces of legislation to pass in the 100th Congress was legislation reauthorizing the Older Americans Act of 1965 (Public Law 100-175). Although the 1987 amendments contained no major overhaul of the act, the law reemphasized prior law requirements to focus the act's resources on those older persons who are in the greatest economic or social need of assistance, with particular attention on low-income minority older persons. The committee played an active role in the reauthorization process, and was instrumental in incorporating the following provisions in the law: Authorizing adult day care centers for the elderly and the chronically impaired disabled to receive funds for meals under the National School Lunch Act and requiring the Secretary of Labor to develop a consumer price index for older persons. The committee also was involved in developing the provisions of the act that strengthen and improve the long-term care ombudsman program. These provisions will help to ensure that frail nursing home residents have access to ombudsmen, who act as advocates on their behalf in resolving inquiries about quality of care concerns and violations of residents' rights.

Building on the improvements in the long-term care ombudsman program, nursing home residents and their advocates achieved another victory with the passage of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203). Extensive nursing home reform provisions within the act include requirements for nurse aide training, the elimination of the distinction between skilled nursing facilities and intermediate care facilities, and the strengthening of residents' rights. This law is the result, in part, of previous committee investigations and hearings on the issue of nursing home reform.

The Housing and Community Development Act of 1987 (Public Law 100-242) was the first major housing authorization bill to be signed into law in 7 years. In keeping with congressional priorities to balance the budget, the act funds most programs at their current levels, and does not provide for any substantial expansion. Provisions of particular interest to the elderly are the reauthorization of the Department of Housing and Urban Development's Section 202/Section 8 program for the elderly and handicapped, a demonstration program for home equity conversion loans, and the provision making permanent the Congregate Housing Services Program.

The above record demonstrates a productive year for the committee and the Congress as a whole measured in legislative accomplishments. The committee's work, however, extends beyond making legislative recommendations. In the past year we have continued to investigate a wide range of problems affecting the elderly, informing the public through committee prints, newsletters, and public hearings. For example, a committee hearing, as well as an ongoing investigation, highlighted widespread discontent about the regulatory, enforcement, and administrative activities of the Equal Employment Opportunity Commission (EEOC) in carrying out its duties under the Age Discrimination in Employment Act of 1967 (ADEA). As a direct result of the hearing came legislation providing workers greater protections under the ADEA. The hearing also led to revelations regarding a large number of charges filed with the EEOC that have exceeded the ADEA's 2- and 3-year statutes of limitations.

Where do we now stand on issues of importance to our Nation's seniors? Despite the significant gains in the first session of the 100th Congress, much remains to be done.

The staggering problem of access to health care for the aged and non-aged alike has been thrust onto the legislative agenda during the past year. Thirty-seven million Americans lack health insurance. One-third of the U.S. population with incomes below the poverty level are uninsured. These statistics highlight gaps in protection for even the most needy Americans. Likewise, while nearly 98 percent of older Americans are enrolled in Medicare, more than one-quarter of their health costs must be paid out-of-pocket.

Although the passage of the catastrophic legislation in both the House and Senate represent an important first step toward protecting the elderly against the costs of catastrophic illness, it focuses on acute, short-term illness, rather than the chronic, long-term illnesses that lead to true catastrophic expenditures. While there are provisions within both the House and Senate-passed bills that will provide information on the need for and availability of long-term care coverage and ways to finance it, there are more than 2 million older Americans facing catastrophic long-term care expenditures who will not be helped by the current legislative effort.

Solving their problems requires a major commitment on the part of the Federal Government, as well as renewed efforts by the private sector. Private long-term care insurance has modestly grown in popularity and availability. However, recent analysis by the Brookings Instititution indicate that even under generous assumptions, private insurance will cover no more than 20 percent of the Nation's long-term care bill by the year 2020. The remainder must come from the public sector, either through an expansion of Medicaid, a redesign of Medicare, or a new Federal program. In response to growing concerns about the provision and financing of long-term care, Volume III of Developments in Aging this year focuses exclusively on this issue.

Beyond the issue of long-term care, expenditures by older Americans and the Medicare Program on physician services and other services reimbursed under Part B of Medicare continue to soar. As this trend continues, so too will pressures to find an alternative physician reimbursement approach. Should this pressure prove to be overwhelming, developing and implementing a new reimbursement method that is fair to both the elderly and physicians, as well as cost effective to the Medicare Program, will be a great challenge to the Congress.

The need for elderly housing continues to increase. A growing elderly population is one factor. Current demographic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. In 1995, 21.4 million households will be headed by Americans over 65.

Rapidly escalating housing costs also have contributed to the need for Federal programs. Housing costs for the elderly are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans. This problem is particularly acute for renters, who pay a far larger share of their incomes for housing than homeowners. Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget savings.

The report that follows discusses development of importance to older Americans in 1987. In line with changes implemented in 1984, the report surveys only Federal policies and programs and focuses exclusively on the major policy issues facing Congress and the legislative activity on these issues that transpired in 1987.

In a break from recent practice, comprehensive demographic and statistical information, normally contained in Volume III, is not included in this year's report because updated data can be found in the 1987-88 edition of Aging America: Trends and Projections. (This publication has recently been released and is available from the Committee.) However, the first chapter of Volume I includes a brief look at 20 of the most significant demographic and statistical trends in aging. As previously mentioned, this year's Volume III has been dedicated solely to providing background information on this long-term care issue. The dedication to one particular issue is based on the Chairman's belief that the long-term care issue represents the No. 1 aging policy challenge and therefore requires special recognition and attention. These and other changes are intended to make this report more informative and easier to use.

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This report is a synthesis of the extensive working knowledge they bring to the committee.

The graying of America presents us with significant challenges and opportunities. Providing for the health and housing needs of this ever-growing older population are only two of many remaining challenges. We must also seek better ways to enable older Americans to be productive and financially independent. Our greatest challenge then is to expand opportunities, to put to use the full talents of this vast resource so that the promise of long life is worth living.

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100TH CONGRESS *2d Session*	SENATE	REPT. 100-291 Volume 1

DEVELOPMENTS IN AGING: 1987 VOLUME 1

FEBRUARY 29, 1988.—Ordered to be printed

Mr. MELCHER, from the Special Committee on Aging, submitted the following

REPORT

Chapter 1

TWENTY TRENDS IN AGING

INTRODUCTION

This chapter summarizes 20 of the most noteworthy trends in aging. The 20 trends are divided into the following sub-headings: (1) Aging population growth, (2) economic status, (3) employment, (4) health, (5) social characteristics, (6) Federal expenditures, and (7) international populations.[1]

A. AGING POPULATION GROWTH

ONE. THE AGING BOOM IS THE DOMINANT FORCE IN POPULATION CHANGE

The older population has increased far more rapidly than the rest of the population for most of this century (table 1). In the last two decades alone, the 65-plus population grew three times as fast as the under-65 population. In fact, the 65-plus population of the United States now is larger than the entire population of Canada. In 1986, one out of eight Americans was over 65 (29 million persons) and one out of five was over age 55 (51 million Americans).

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[1] The trends described in this chapter have been adapted in part from the 1987-88 edition of the Senate Special Committee on Aging publication, Aging America: Trends and Projections. Analysis of the 1987 Census Population Survey was prepared by Thomas Gabe of the Congressional Research Service.

The baby-boom generation (age 22–41) will join the aging boom early in the next century. When this group reaches 65, one in five Americans will be elderly.

TABLE 1.—ACTUAL AND PROJECTED GROWTH OF THE OLDER POPULATION

[Numbers in thousands]

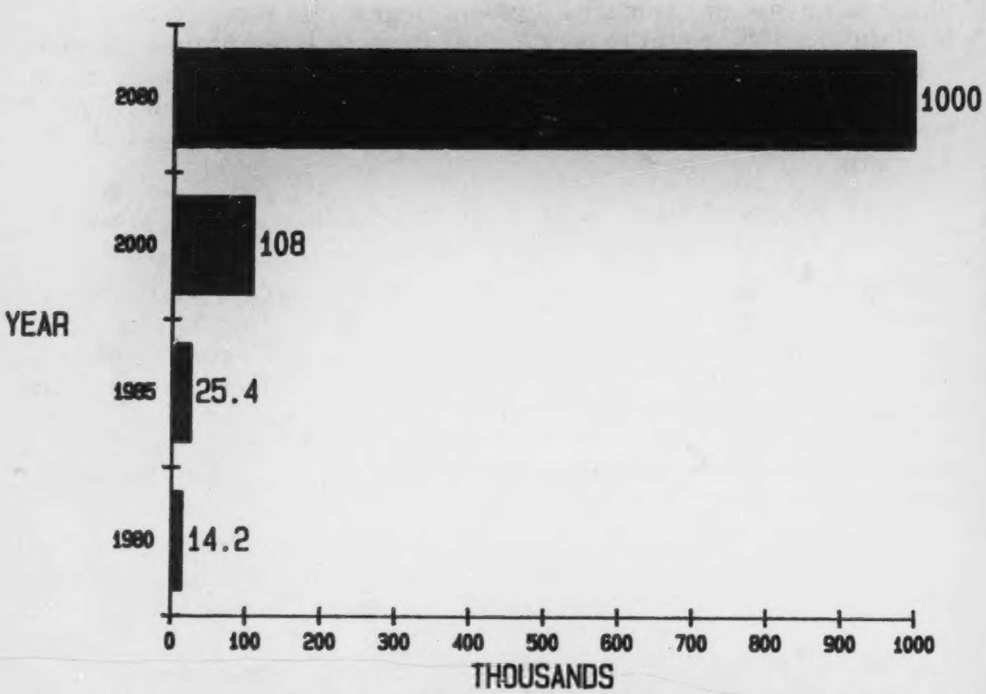
Year	Total population all ages—number	65 years and older	
		Number	Percent
1900	76,803	3,084	4
1910	91,972	3,950	4
1920	105,711	4,933	5
1930	122,775	6,634	6
1940	131,669	9,019	7
1950	150,967	12,270	8
1960	179,323	16,560	9
1970	203,302	19,980	10
1980	226,505	25,544	11
1990	249,657	31,697	13
2000	267,955	34,921	13
2010	283,238	39,195	14
2020	296,597	51,422	17
2030	304,807	64,581	21
2040	308,559	66,988	22
2050	309,488	67,411	22

The 85-plus population is one of the fastest growing age groups in the country. The 85-plus population is expected to increase nearly four times between 1980 and 2030 and seven times by 2050.

More people also are surviving into their 10th and 11th decades. The Bureau of the Census estimates that there were about 15,000 people 100 or older in 1980, and that this age group increased to about 25,000 by 1986. Centenarians are projected to number more than 100,000 by 2000 and over a million by 2080, if the Census Bureau's middle series projections hold true (chart 1).

CHART 1

CENTENARIANS



Source: U.S. Bureau of the Census, Current Population Reports, Series P-23, No. 153, America's Centenarians, 1987

TWO. BY 2020 THERE WILL BE 3 ELDERLY PERSONS FOR EVERY 10 WORKING AGE PERSONS COMPARED TO 2 TO 10 IN 1986

The fact that people are living longer and families are having fewer children means there are fewer working age persons in relation to elderly persons. In 1986, there were about 2 elderly persons per 10 of working age. By 2020, the ratio will rise to about 3 for every 10. By 2030, it will be about 4 per 10. This ratio, often called a support or dependency ratio, is important because the working population can be thought of as supporting nonworking age groups.

THREE. OLDER WOMEN OUTNUMBER OLDER MEN

Today, there are three elderly women for every two elderly men. The disparity in the sex ratio becomes more pronounced with age. For those 85 and over, there are five women for every two men. These statistics reflect the fact that women live, on average, 7 years longer than men.

Four. Life Expectancy is at a Record High

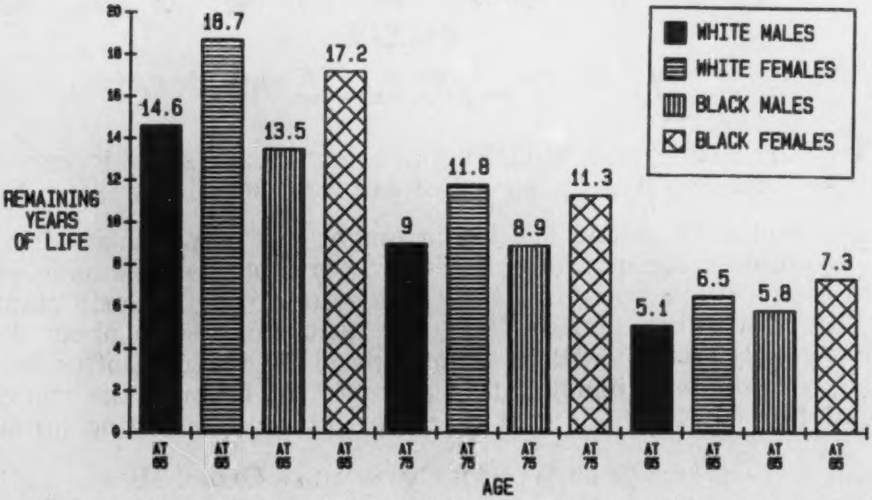
There has been a remarkable increase in life expectancy since the turn of the century. A baby born in 1900 could expect to live an average of 47 years, while a baby born in 1985 could expect to live an average of 75 years. In this century, life expectancy at age 65 also has advanced dramatically. Americans who reached their 65th birthday in 1985 could expect, on average, to live another 17 years compared to 12 years at the turn of the century. The Bureau of the Census projects that elderly men can expect to gain an additional 3 years by the year 2050 and women can expect to gain an additional 4.5 years.

Five. Whites Live Longer Than Blacks, Except for Those Over 85

In general, whites live longer than blacks, except at the upper age ranges where blacks live longer than whites. In 1985, for example, at age 65, blacks could expect to live 15.5 years compared to 17 for whites. However, detailed data for 1984, the most recent information available, demonstrates that blacks at age 85 could expect to live another 7 years compared with 6 years for whites. Chart 2 shows differences in life expectancy at age 65, 75, and 85 for whites and blacks by sex.

CHART 2

LIFE EXPECTANCY AT SPECIFIED AGES BY RACE AND SEX:
1984



Source: National Center for Health Statistics, Vital Statistics of the United States

Six. The Suburbs and the Sunbelt are Graying

In 1980, for the first time, a greater number of older persons lived in the suburbs (10.1 million) than in the central cities (8.1 million). Older persons are found disproportionately in suburbs that were developed before World War I. These older suburbs also have lower average resident income levels, more rental housing, lower home values, and higher population densities.

Specific parts of the country—such as the Sunbelt States—also are experiencing an aging of the population due to the large number of retirees who move to temperate climates. Florida remains the State with the oldest population. Half of all Floridians are over 36. Eighteen percent of Florida's population is 65 or older, the highest in the country. Table 2 ranks the 50 States by number and proportion of the population that is elderly.

TABLE 2.—RANK ORDER OF STATES BY NUMBER AND PROPORTION OF ELDERLY: 1986

Number of persons 65+			Persons 65+ as percent of State's population		
Rank	State	Number (thousands)	Rank	State	Percent
1 (1)	California	2,766	1	Florida	17.6
2 (2)	New York	2,254	2	Rhode Island	14.4
3 (6)	Florida	2,001	3	Arkansas	14.3
4 (4)	Pennsylvania	1,698	4	Pennsylvania	14.3
5 (3)	Texas	1,538	5	Iowa	14.3
6 (4)	Illinois	1,368	6	South Dakota	13.7
7 (7)	Ohio	1,296	7	Missouri	13.7
8 (8)	Michigan	1,022	8	Nebraska	13.5
9 (9)	New Jersey	954	9	Massachusetts	13.4
10 (12)	Massachusetts	783	10	Kansas	13.3
11 (10)	North Carolina	708	11	West Virginia	13.3
12 (15)	Missouri	687	12	Maine	13.2
13 (14)	Indiana	645	13	Oregon	13.2
14 (16)	Wisconsin	617	14	Connecticut	13.0
15 (22)	Georgia	594	15	Wisconsin	12.9
16 (13)	Virginia	587	16	North Dakota	12.7
17 (17)	Tennessee	576	17	New York	12.7
18 (21)	Minnesota	522	18	New Jersey	12.6
19 (19)	Washington	505	19	Minnesota	12.5
20 (22)	Alabama	487	20	Arizona	12.3
21 (20)	Maryland	458	21	Oklahoma	12.3
22 (23)	Kentucky	444	22	District of Columbia	12.1
23 (18)	Louisiana	441	23	Alabama	12.1
24 (28)	Connecticut	413	24	Tennessee	12.1
25 (29)	Iowa	413	25	Ohio	12.1
26 (25)	Oklahoma	405	26	Kentucky	11.9
27 (27)	Arizona	392	27	Mississippi	11.9
28 (30)	Oregon	354	28	Illinois	11.9
29 (24)	South Carolina	342	29	Montana	11.8
30 (33)	Arkansas	338	30	Vermont	11.8
31 (32)	Kansas	326	31	Indiana	11.7
32 (31)	Mississippi	310	32	New Hampshire	11.6
33 (26)	Colorado	285	33	Washington	11.4
34 (34)	West Virginia	257	34	North Carolina	11.3
35 (36)	Nebraska	217	35	Michigan	11.2
36 (38)	Maine	153	36	Delaware	11.2
37 (42)	Rhode Island	139	37	Idaho	10.9
38 (37)	New Mexico	139	38	California	10.5
39 (35)	Utah	130	39	Maryland	10.4
40 (41)	New Hampshire	116	40	Virginia	10.3
41 (40)	Idaho	109	41	South Carolina	10.2
42 (39)	Hawaii	99	42	Georgia	9.9
43 (44)	Montana	98	43	Nevada	9.9
44 (45)	South Dakota	97	44	Louisiana	9.8
45 (43)	Nevada	93	45	New Mexico	9.6
46 (46)	North Dakota	87	46	Texas	9.4
47 (47)	District of Columbia	76	47	Hawaii	9.4
48 (48)	Delaware	70	48	Colorado	8.8

TABLE 2.—RANK ORDER OF STATES BY NUMBER AND PROPORTION OF ELDERLY: 1986—Continued

Number of persons 65+			Persons 65+ as percent of State's population		
Rank	State	Number (thousands)	Rank	State	Percent
49 (49)	Vermont	63	49	Wyoming	8.3
50 (51)	Wyoming	42	50	Utah	7.9
51 (50)	Alaska	17	51	Alaska	3.2

Source: U.S. Bureau of the Census, "State Population and Household Estimates," Current Population Reports, Series P-25, December 1986.

B. ECONOMIC STATUS

Seven. Many Elderly Remain Poor Despite Gains

The economic status of the elderly has improved steadily since the 1960's. For example, the poverty rate among those 65 and older was halved from 28.5 percent in 1966 to 14.6 percent in 1974. In constant 1986 dollars the median family income of persons older than 65 rose from $12,311 to $16,682 during the same time period.

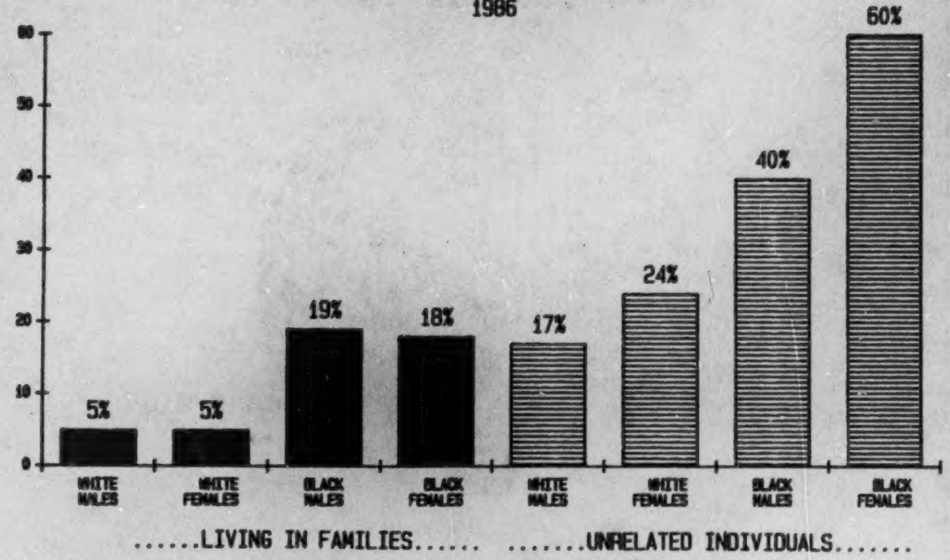
The real incomes of the elderly continued to rise, albeit slowly, during the remainder of the 1970's and 1980's. In 1986 the median family income of the elderly was $19,922 and the poverty rate was 12.8 percent.

The recent improvements in elderly incomes have been interpreted by some as meaning that the economic problems of the elderly have been solved. This conclusion is not true. In fact, elderly persons are more likely than other adults to be poor. In turn, they are more likely than the non-elderly to be "near poor." In 1986, 15.5 percent of persons 65 and older were in families with incomes between the poverty level and one and one half times the poverty level. At the same time, only 8.4 percent of those under 65 were in families with incomes that fell within this range.

The people who are the worst off among the elderly are "unrelated individuals," people who do not live with relatives. Unrelated individuals who are women or minorities, or both, are the worst off (chart 3).

CHART 3

PERCENT OF ELDERLY BELOW POVERTY
BY RACE, SEX AND FAMILY STATUS
1986



Source: 1987 Current Population Survey

The risk of poverty also increases with age. In 1986, 18 percent of the 85-plus population were poor and 15 percent of the 75–84 age group were poor compared to 10 percent of those 65–74.

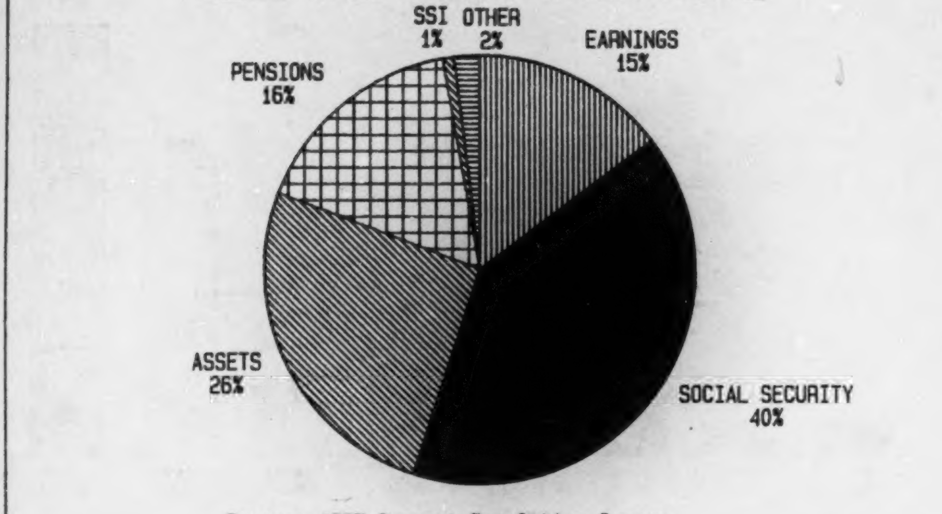
EIGHT. THE ELDERLY RELY HEAVILY ON SOCIAL SECURITY

The elderly depend more heavily on Social Security than any other source of income. In 1986, 40 percent of all income of elderly married couples and individuals came from Social Security.

The role of earnings in the income of the elderly has changed significantly. Labor force participation rates of men 65 and older have dropped from 33 percent in 1960 to 16 percent in 1986. As a result, earnings accounted for only 15 percent of elderly income in 1986 (chart 4).

CHART 4

SOURCES OF INCOME
ELDERLY MARRIED COUPLES AND INDIVIDUALS: 1987



Source: 1987 Current Population Survey

NINE. THE GREATEST THREAT TO THE ECONOMIC SECURITY OF THE ELDERLY IS THE COST OF HEALTH AND LONG-TERM CARE

Out-of-pocket costs of health care place a substantial financial burden on the incomes of the elderly. In fact, current average out-of-pocket costs to elderly Medicare beneficiaries remain at the same level they were when Medicare was enacted (15 percent).

The cost of long-term care places older Americans at great risk of impoverishment. While the median income of elderly families is $19,922, annual costs of nursing homes can range from $12,000 to $50,000. According to a preliminary analysis of the 1982–84 National Long-Term Care Survey, one out of 3 elderly who spend any time in a nursing home ends up poor. This finding is consistent with an analysis by the House Select Committee on Aging which found that 7 in 10 elderly living alone find their income spent-down to the poverty level after only 13 weeks in a nursing home.

C. EMPLOYMENT

TEN. ALMOST TWO-THIRDS OF OLDER WORKERS RETIRE BEFORE AGE 65

Since Social Security was passed in 1935, age 65 has been commonly thought of as the "normal" retirement age. Today, however, most retirees leave work before they reach 65. A 1978 national survey of American attitudes toward pensions and retirement, the most recent data available, found that almost two-thirds of retirees had left work before 65. The median age of retirement in this sample was 60.6. According to research by the National Commission for Employment Policy, even an increase in the eligibility age for full Social Security benefits and the elimination of mandatory retirement at age 70 is likely to have only minimal impact on future retirement ages.

ELEVEN. THREE-FOURTHS OF THE LABOR FORCE WOULD LIKE TO CONTINUE SOME KIND OF PART-TIME WORK AFTER RETIREMENT

According to results of a national poll conducted by Lou Harris in 1981, the most recent data available, about three-fourths of the labor force would prefer to continue some kind of paid part-time work after retirement. The majority of the older labor force respondents to this survey felt that a flexible work schedule would benefit retirees.

Although the actual number of older persons working part-time does not begin to equal the number who report that this would be desirable, almost half (48 percent) of all males over 65 and almost two-thirds of women (61 percent) were working part-time in 1986.

D. HEALTH

TWELVE. OLDER PEOPLE VIEW THEIR HEALTH POSITIVELY, BUT DISABILITY DOES INCREASE WITH AGE

Contrary to popular opinion, older people, on average, view their health positively. According to results of the 1985 health interview survey conducted by the National Center for Health Statistics, 69 percent of elderly persons living in the community describe their health as excellent, very good or good compared with others their age; only 31 percent report that their health is fair or poor. At the same time, the proportion of persons experiencing difficulty with daily life activities—a measure frequently used to measure disability—increases with age. For example, results of a 1984 supplement to the National Health Interview Survey show that the proportion of elderly persons reporting difficulty with one or more personal care activities rose from 15 percent for people 65–69 to 49 percent for people 85 and older (table 3).

TABLE 3.—PERCENT DISTRIBUTION OF PERSONS 65 AND OLDER BY NUMBER OF PERSONAL CARE ACTIVITIES THAT ARE DIFFICULT, ACCORDING TO SEX AND AGE: UNITED STATES, 1984

[In percent]

Sex and age	Total	Number of personal care activities that are difficult				
		None	1	2	3	4 to 7
Both sexes:						
65 years and older	100	77.3	9.2	4.7	2.8	5.9
65 to 74 years	100	82.9	7.8	3.7	1.9	3.7
65 to 69 years	100	85.3	6.8	3.1	1.5	3.2
70 to 74 years	100	79.9	9.1	4.4	2.4	4.2
75 to 84 years	100	72.2	11.2	5.4	3.7	7.4
75 to 79 years	100	75.9	10.8	4.3	3.3	5.7

TABLE 3.—PERCENT DISTRIBUTION OF PERSONS 65 AND OLDER BY NUMBER OF PERSONAL CARE ACTIVITIES THAT ARE DIFFICULT, ACCORDING TO SEX AND AGE: UNITED STATES, 1984—Continued

[In percent]

Sex and age	Total	Number of personal care activities that are difficult				
		None	1	2	3	4 to 7
80 to 84 years	100	65.6	12.1	7.4	4.6	10.4
85 years and older	100	51.2	12.8	10.2	6.7	19.2

Source: Dawsen, Deborah et. al., "Aging in the Eighties: Functional Limitations of Individuals Age 65 and Over" Advance Data No. 133, National Center for Health Statistics, June 10, 1987.

Thirteen. Only About 5 Percent of the Elderly Population Are in Nursing Homes at Any Given Time

In contrast to the stereotype that the elderly are "warehoused" in institutions, only about 5 percent of the elderly population are in nursing homes at any given time, according to the 1985 National Nursing Home Survey. In 1985, an estimated 1.3 million elderly Americans lived in nursing homes during the year. An estimated 1 percent of those age 65–74 were residents, compared to about 6 percent of those 75–84 and about 22 percent of persons 85 and older. Three-quarters of nursing home residents are women, two-thirds are widowed, almost half are 85 or older and 9 out of 10 are white.

Fourteen. Relatives Are the Primary Caregivers to Older Persons

The assertion that families have deserted the elderly is a myth. Eighty-four percent of all caregivers of older males and 79 percent of all caregivers of older females are friends, spouses, or other relatives. More wives than husbands provide care to disabled spouses, reflecting the fact that women outlive men by an average of 7 years. Almost 2 out of 5 elderly disabled men living in the community are cared for by their wives while only 1 in 10 elderly disabled women are cared for by their husbands.

E. SOCIAL CHARACTERISTICS

Fifteen. Most Older Men Are Married, But Most Older Women Are Widowed

The longevity advantage of older women unfortunately means that the majority spend their later years alone. While most older men remain married until they die, most older women are widowed. In 1987, 7 out of 10 men 75 and older were married and living with their spouse compared with 2 out of 10 women in this age group. Similarly, 7 out of 10 women 75 and older are widowed compared with 2 out of 10 men.

Sixteen. The Elderly and Near Elderly Are the Most Likely Age Groups To Vote

In both the 1984 and 1986 elections, persons 55–64 were the most likely to vote, followed by persons 65–74 (table 4). In the 1986 congressional elections, those 55 and older accounted for 38 percent of

all voters. In the 1984 election, persons in this age group represented 33 percent of all voters.

TABLE 4.—NUMBER AND PERCENTAGE OF PERSONS WHO REPORTED VOTING BY AGE GROUPS—1980–86

[Numbers in thousands—excludes people in institutions]

Age group	1980		1982		1984		1986	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
18 plus	93,006	59.2	80,310	48.5	101,878	59.9	79,954	46.0
18 to 19	2,788	34.2	1,468	18.3	2,596	35.1	1,201	16.9
20 to 24	8,438	42.2	5,671	27.2	8,811	42.8	4,580	23.7
25 to 34	19,498	54.6	15,667	40.4	21,978	54.5	14,720	35.1
35 to 44	16,460	64.4	14,676	52.2	19,514	63.5	16,283	49.3
45 to 54	15,174	67.5	13,350	60.1	15,035	67.5	12,544	54.8
55 to 64	15,031	71.3	14,141	64.4	15,889	72.1	13,761	62.7
65 to 74	10,622	69.3	10,312	64.8	11,761	71.8	11,117	65.1
75 plus	5,055	57.6	5,024	51.9	6,294	61.2	5,748	54.0

Sources: U.S. Bureau of the Census. "Voting and Registration in the Election of November 1980." Current Population Reports Series P–20, No. 370 (April 1982). U.S. Bureau of the Census. "Voting and Registration in the Election of November 1982." Current Population Reports Series P–20, No. 383 (November 1983). U.S. Bureau of the Census. "Voting and Registration in the Election of November 1984." Current Population Reports Series P–20, No. 405 (March 1986). U.S. Bureau of the Census. Unpublished data from the November 1986 Current Population Survey.

F. FEDERAL EXPENDITURES

SEVENTEEN. 26 PERCENT OF THE FEDERAL BUDGET IS SPENT ON PROGRAMS FOR THE ELDERLY

Since 1960, the share of the Federal budget spent on programs serving the elderly has nearly doubled. In 1960, less than 15 percent of the Federal budget was spent on the elderly. In fiscal year 1986, programs benefiting the elderly accounted for 26 percent of the Federal budget, down from 28 percent in 1984 (table 5).

TABLE 5.—FEDERAL OUTLAYS BENEFITING THE ELDERLY: 1984–86

[In millions of dollars]

Type of outlay	Fiscal year—		
	1984 actual	1985 actual	1986 actual
Medicare	53,307	60,907	64,417
Medicaid	7,435	8,057	8,878
Other Federal health	4,138	4,573	4,662
Health subtotal	64,880	73,537	77,957
Social Security	129,284	137,852	146,235
Supplemental security income [SSI] [2]	3,547	3,649	3,719
Veterans compensation-pensions	5,031	5,745	6,113
Other retired, disabled, and survivors benefits	23,689	24,634	25,863
Retirement/disability subtotal	161,551	171,880	181,930
National Institute on Aging	100	126	132
Older Americans volunteer programs	92	102	106
Senior community service employment	321	320	323
Administration on Aging	824	825	836
Subsidized housing [3] [4]	4,338	9,166	4,870
Section 202 elderly housing loans [5]	595	501	490
Farmers Home Administration Housing	40	55	84
Food stamps [6]	610	615	612

TABLE 5.—FEDERAL OUTLAYS BENEFITING THE ELDERLY: 1984–86—Continued

[In millions of dollars]

Type of outlay	Fiscal year—		
	1984 actual	1985 actual	1986 actual
Social services (title XX)	366	369	369
Low income home energy assistance [7]	608	642	606
Other miscellaneous [8]	1,490	1,185	1,193
Other subtotal	9,385	13,906	9,622
Total elderly outlays	235,815	259,322	269,505
Percentage of total Federal outlays [9]	28	27	26

[1] Much of the data used to compile this table is based on unsubstantiated estimates and preliminary program and demographic information. Most estimates are for recipients age 65 and over and include the effects of proposed legislation such as COLA freeze, we well as rough estimates of the effect of Gramm-Rudman-Hollings on fiscal year 1986 outlays. Some federal programs (e.g., consumer activities, USDA extension services, national park services) have been excluded due to lack of data.

[2] Fiscal year 1984 outlays reflect an 11-month benefit period.

[3] HUD defines "elderly" beneficiaries as households with head of household 62 and over.

[4] Financing changed from loan guarantees to direct loans resulting in one time fiscal year 1985 outlay increases in Public Housing.

[5] Reflects net disbursements for new direct loans.

[6] Includes nutrition assistance to Puerto Rico.

[7] Based on 30 percent of total program obligations.

[8] Drop in unemployment rates and associated reduction in outlays causes the decrease between fiscal years 1984–85.

[9] Total Federal outlays includes items categorized as off-budget before fiscal year 1985.

Source: Executive Office of the President, Office of Management and Budget, February 1986.

Eighteen. Social Security Solvency Is Anticipated for the Next 75 Years, but Medicare Faces a Deficit Near the Turn of the Century

Under current projections based on intermediate assumptions, Social Security fund trustees predict that the trust funds will remain solvent throughout the next 75 years. At the same time, without current changes in the law, intermediate assumptions reported by the Medicare trust fund's board of trustees predict that the Medicare hospital insurance trust fund will be depleted near the turn of the century.

Nineteen. The Cost of Health Care Is the Major Policy Issue Concerning Older Americans and the Federal Budget

Rising health care costs are placing an increasing burden on the Federal budget. Persons 65 and older (12 percent of the population), account for a third of the Nation's personal health care expenditures. According to the Office of the Actuary of the U.S. Department of Health and Human Services, total national health expenditures in 1986 were $458.2 billion (10.9 percent of GNP). Even given today's apparent slower rate of increase, health care expenditures are expected to reach $647.3 billion (12 percent of GNP) by 1990 and almost $1.53 trillion (15 percent of GNP) by 2000.

G. INTERNATIONAL POPULATIONS

Twenty. The United States has the Third Largest Elderly Population and the Largest 80-Plus Population in the World

In 1985, the U.S. population of 28.6 million persons 65 and older was the third largest in the world after China and India. The 1985

U.S. population of 6.2 million persons 80 and older was the largest in the world (table 6).

TABLE 6.—*Countries with more than 5 million elderly (65+) and 1 million old-old (80+): 1985*

[1985 population in specified age group]

Country	*Thousands*
Age 65 plus:	
China	52,889
India	32,698
United States	28,609
Soviet Union	25,974
Japan	12,125
West Germany	8,812
United Kingdom	8,466
Italy	7,443
France	6,748
Indonesia	5,901
Brazil	5,828
Age 80 plus:	
United States	6,198
China	5,697
Soviet Union	4,610
India	2,913
Japan	2,000
West Germany	1,951
France	1,741
United Kingdom	1,732
Italy	1,436

Source: Unpublished data from the United Nations, 1984 Assessment of World Population Prospects and the U.S. Bureau of the Census. Center for International Research, as reported in Torrey, Barbara Boyle, Kevin G. Kinsella, and Cynthia M. Taueber, U.S. Bureau of the Census. "An Aging World" (forthcoming).

Chapter 2

SOCIAL SECURITY—RETIREMENT AND DISABILITY

OVERVIEW

In 1987, attention to Social Security remained relatively modest. Long-term concerns continued to focus on Social Security's relation to other Government programs and to the unified budget process, despite 1985 legislation that removed Social Security from the budget. Congress also continued its concern with a variety of issues involving the Social Security Administration's (SSA's) program administration.

Social Security gained the most attention in the area of deficit reduction. During November, congressional leaders met with administration officials to negotiate a deficit reduction agreement and thereby avoid a Gramm-Rudman-Hollings sequester. While many Members of Congress had long been urging a responsible dialog between the White House and the Congress, the October 19 stock market crash forced the realization that the time for a bipartisan budget "summit" had arrived.

In hopes of rebuilding the confidence of the public and stock market investors, the President announced his willingness to negotiate a compromise deficit reduction package and his intent to put "everything but Social Security" on the table. This statement followed SSA's October announcement that Social Security recipients would be eligible to receive a 4.2 percent cost-of-living (COLA) increase in 1988. Upon hearing the President's statement that Social Security COLA's would be protected, many retirees covered by Federal retirement programs other than Social Security became fearful that they would not receive a COLA increase. To add fuel to the fire, as budget discussions proceeded, many economists espoused their belief that no deficit reduction package would be taken seriously until and unless cuts in entitlements, including Social Security, were included. However, the fears of these retirees were allayed when budget negotiators chose to leave all COLA's untouched. Effective January 1, 1988, participants in all Federal retirement plans received a 4.2 percent COLA increase.

Prior to the budget discussions, management of the SSA was the focus of congressional attention in 1987. The problems receiving the most discussion included the closing of SSA field offices, staff reductions, employee morale, telephone accessibility, payment accuracy, and mismanagement of computer contracts.

In 1987, the implementation of the Social Security Disability Benefits Reform Act of 1984 continued to be the major focal point of action related to the Disability Insurance (DI) program. However, a number of other narrower, but significant, issues concerning the operation and benefits of the DI program also received notable attention.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Background

Old age and survivors insurance (OASI) and disability insurance (DI) benefits, known together as the OASDI program, are the basic benefits provided under title II of the Social Security Act. They are based on a worker's earnings in Social Security-covered employment and are designed to replace a portion of the income that individuals and families lose when workers retire, die, or become disabled. At the end of August 1987, approximately 38 million beneficiaries under the OASDI program were receiving $16.8 billion in monthly cash benefits. Retired workers numbered 23.3 million and accounted for 61 percent of all OASDI beneficiaries. Disabled workers numbered nearly 2.77 million and accounted for 7 percent of the total. Average monthly benefit amounts payable in August were $491.34 for retired workers and $487.50 for disabled workers.

The functions of SSA touch the lives of nearly every American. During 1986, about 122 million workers made contributions to the OASDI program. At the end of September 1986, 37.5 million persons were receiving monthly OASDI benefit payments. Administrative expenses represented about 1.1 percent of benefit payments in fiscal year 1986, down slightly from 1985.

In 1986, income to the OASDI trust funds was $215.5 billion, while outgo was $198.7 billion. Outgo included $10.6 billion, which was transferred from the OASI fund to the Hospital Insurance (HI) fund, as a final repayment of interfund loans made in 1982. Thus, the assets of the OASDI funds increased by approximately $6.1 billion during the fiscal year, from $39.7 billion at the end of fiscal 1985 to $45.9 billion at the end of fiscal 1986. By the end of July 1987, trust fund assets have increased further to approximately $62.5 billion.

(A) HISTORY AND PURPOSE

Created during the Great Depression, the Social Security program was touted by many as an unprecedented social advance. The Depression was a painful reminder that the United States was by no means immune from uncontrollable socio-economic forces which can generate massive unemployment, hunger, and despondency. As a result, the Roosevelt administration was hard-pressed to rapidly unearth solutions which would alleviate rampant individual misfortune. Thus, the immediate purpose of the Social Security Act of 1935 was not to thwart the underlying causes of poverty and unemployment, but rather to serve as a pragmatic solution to an immediate crisis.

While Social Security is presently viewed by many as primarily a program to benefit the elderly, its architects viewed the economic woes of older Americans in their generational context. The program's founders believed that by first addressing the problems of the aged, the troubles of the young and middle-aged would also be alleviated. While younger age groups would benefit indirectly from Social Security's guarantee of aid to their elders, they would receive an additional, direct benefit of added retirement security for themselves.

While Social Security has expanded and changed substantially over the course of its development, the basic principles which guided its framers have remained unaltered. President Roosevelt viewed this new experiment as the centerpiece "for the kind of protection America wants." Today, Social Security continues to provide a blanket of protection to Americans of all ages.

The design of Social Security reflects a compromise among a variety of purposes. This compromise is both a key to the program's broad-based political support and a cause of much of the criticism it receives. For while Social Security provides a mixture of insurance protection, earned pension benefits, and minimally adequate income in old age, it must make separate concessions in the value of each to achieve a combination that works. One current method of criticizing the program has been to evaluate the quality of benefits from only one perspective. For instance, many point to the possibility that rates of return on Social Security taxes paid by the highest wage earners may, in the long run, compare poorly with the rates of return on private investments. While it may be popular when discussing Social Security with a younger worker to focus on only one aspect of the system, this results in a distorted evaluation of the larger purposes of Social Security.

To ensure an accurate picture of the program, there are a number of features that should be factored into any equation which attempts to measure the value of Social Security.

First, Social Security provides younger workers with protection from the unpredictable and random costs of financial support for their own aged parents and relatives. The pay-as-you-go financing for Social Security, seen from this perspective, uses periodic payments by younger workers to insure their own earnings against the cost of parental support. By spreading these costs across the working population, younger workers have a smaller, fairer, and more predictable financial burden, and their parents have a degree of financial independence. This aspect of the program justifies universal coverage, since exemptions from coverage permit individuals to pass to others the costs of supporting their own parents. It also justifies features which will provide adequate retirement and survivors benefits, so that younger workers will be fully protected from having to supplement the incomes of their relatives.

Second, Social Security provides workers and their families with a "floor of protection" against sudden loss of their earnings due to their own death, disability, or retirement. This insurance is intended to protect only a portion of the income needed to preserve the previous living standard of the worker and his family, and is to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker. Receipt of benefits is based on the occurrence of an insured-against event, such as retirement, which is determined by comparing the individual to some test or standard, such as the retirement or earnings test. Should the individual meet the test, benefits are then provided regardless of any income from other sources.

Third, Social Security provides the individual wage earner with basic pension benefits upon retirement. Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating service credits. This mixture of features in Social Security has been the source of public confusion about the program over the years. The similarities between Social Security and a pension, for example, have led many people to believe that the system is funded, as a private pension might be, through workers' contributions invested in a trust fund account and used to pay benefits in the future. Others focus on the rate of return on contributions—as if Social Security were a form of individual investment.

The essential social functions and multiple purposes of Social Security defy comparison with other financial or insurance vehicles. No single instrument could perform the unique combination of functions without approximating Social Security in its features. Most criticisms of Social Security, therefore, readily translate into criticisms of its mix of functions. For example, some critics believe Social Security ought to be only a pension plan, leaving the insurance and intergenerational support functions to specially tailored alternative programs. Others argue that Social Security should be a welfare program, providing basic benefits to the poor, and allowing middle- and upper-income workers to invest their earnings in private vehicles, such as IRA's. Though the use of separate programs would eliminate the compromises entailed in Social Security, it could also raise tremendously the total cost of performing all of Social Security's multifaceted functions, and most likely would jeopardize the widespread political support that has developed for the program.

The Social Security program is only now coming of age. The decade of the 1980's marks the first generation of lifelong contributors retiring and beginning to draw benefits. Also during this decade, it is expected that payroll tax rates, eligibility requirements, and the relative value of monthly benefits will finally stabilize at the levels planned for the system.

(B) FINANCING

(1) Financing in the 1970's

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to meet any disruptions in expenditures or income due to unforeseen economic fluctuations. When the Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: Relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecasted. The energy crisis, high levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 not only increased benefits by 20 percent across-the-board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

In 1977, recognizing that the financial status of the Social Security trust funds was rapidly deteriorating, the Congress responded with new amendments to the Social Security Act. The Social Security Act of 1977 increased payroll taxes beginning in 1979, reallocated a portion of the Medicare (HI) payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as forecasts had predicted. The long-term deficit, which had not been fully reduced, remained. The stagflation occurring after 1979 resulted in annual CPI increases exceeding 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

The 96th Congress responded to this crisis by temporarily reallocating a portion of the DI tax rate to OASI for 1980 and 1981. This measure was intended to postpone an immediate financing crisis in order to allow time for the 97th Congress to comprehensively address the impending insolvency of the OASDI trust funds. In 1981, a number of proposals were introduced to restore short- and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial, and enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By

November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay imposed by the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. But the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(2) The Social Security Amendments of 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, the Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package improved financing by $166 billion between 1983 and 1989, and eliminated a deficit which had been expected to average 2.1 percent of payroll over 75 years.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions for new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI program resulting from the 1983 Social Security amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions included are:

> *Coverage.*—All Federal employees hired after January 1, 1984, were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.
>
> *Benefits.*—COLA increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA fail-safe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.
>
> *Taxation.*—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue in turn being funneled back into the retirement trust fund.

Payroll Taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement Age Increase.—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the year 2000 to 2022.

(3) Trust Fund Projections

Future trust fund income and outgo will depend on a variety of economic and demographic factors, including economic growth, inflation, unemployment, fertility, and mortality. To predict the future state of the OASI and DI trust funds, estimates are prepared using four different sets of assumptions: Alternative I is designated as the most optimistic, followed by intermediate assumptions II–A and II–B, and finally the more pessimistic alternative III. Actual experience, however, could fall outside the bounds of any of these assumptions.

One indicator of the health of the trust funds is the contingency fund ratio. This ratio represents the ability of the trust funds to pay benefits in the near future. The ratio is determined from the percentage of a year's payments which can be paid with the reserves available at the beginning of the year. Therefore, a contingency ratio of 50 percent represents 6 months of outgo.

Reserve ratios hit a low of 11 percent at the beginning of 1983, but had increased to approximately 31 percent by 1987. Based on intermediate assumptions, the contingency fund ratio is projected to increase gradually to 70 percent by the beginning of 1990. Under pessimistic assumptions, however, assets are projected to grow more slowly and reach 49 percent by the beginning of the next decade.

(a) OASDI Near-Term Financing

Trust fund assets grew more rapidly in 1987 than predicted. Such increases may be expected to continue over the next 5 years. Indeed, according to the 1987 OASDI trustees report, OASDI assets will be sufficient to meet the required benefit payments throughout and far beyond the upcoming 5-year period. Under all but the most pessimistic assumptions, both the OASI and DI programs will remain solvent on their own for many years. However, should conditions deteriorate drastically during the coming 10 years, DI trust fund assets could decline to dangerously low levels.

Overall, the OASDI reserves are expected to expand considerably in the near future. This expansion will be aided by two scheduled payroll tax increases—from 7.15 percent to 7.51 percent (with an upper limit of $45,000) in 1988 and a 1990 increase to 7.65 percent. Under all sets of assumptions in the 1986 Social Security trustees report, the OASDI contingency funds were expected to remain between 28 and 31 percent of projected outgo until 1988. Beginning in 1988, the OASDI reserves are expected to begin a steady buildup as a result both of the scheduled 1988 and 1990 tax increases and an anticipated leveling off in the growth rate of new retirees.

(b) OASDI Long-Term Financing

In the long run, the Social Security trust funds appear to be in close actuarial balance, meaning that over the next 75 years, it is projected that the taxes collected for Social Security will fall within plus or minus 5 percent of the amount needed to pay benefits. Under current projections based on intermediate assumptions, the trustees predict that the trust funds will remain solvent throughout the next 75 years.

Although forecasted to remain healthy for the long term, it should be emphasized that the OASDI trust funds experience in each of the three 25-year periods between 1987 and 2061 varies considerably. In the first 25-year period—1987 to 2011—the trust funds are expected to accumulate rapidly, and maintain an annual surplus of revenues equal to 2.1 percent of taxable payroll. As a result of these surpluses, contingency fund ratios are expected to build to approximately 258 percent by the year 2000.

In the second 25-year period—2012 to 2036—the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow to approximately 545 percent of annual expenditures by 2015, and then decline to 270 percent of outgo by 2035. Positive actuarial balances are expected through the year 2015, with negative balances occurring thereafter. Negative deficits are projected to peak around the year 2035, at 2.98 percent of taxable payroll. This combination of surpluses and deficits will result in an average deficit of 1.22 percent of taxable payroll over this 25-year period.

The third 25-year period—2037 to 2061—is expected to be one of continuous deficits. Program costs will grow until 2035 and level off, remaining above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Under intermediate assumptions, exhaustion of reserves is projected to occur by 2051. If considered separately, depletion of DI reserves is expected by 2023, while OASI trust fund exhaustion is projected for the year 2055. Annual OASDI deficits over the 25-year period are expected to average 2.74 percent of taxable payroll.

(c) Midterm Surpluses

In the years between 1990 and 2015, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these surpluses will be invested in interest-bearing Federal securities, and will be redeemable to Social Security in the years in which benefit expenditures exceed payroll tax revenues—2015 through 2060. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used, indirectly, to finance other Government expenditures or reduce the public debt. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represents internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though the net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequences. The significance lies with the fact that there will be incentive to spend surplus revenues in the 1990's, and cut back on underfunded benefits after 2020.

What will happen to the surpluses Social Security lends to the general fund? These funds will enable Congress to spend money elsewhere without raising taxes or borrowing. This money could be used to fund new Federal programs, to reduce and possibly eliminate the budget deficit, or, with sufficient surpluses, to pay off the national debt. What will happen when this debt has to be repaid to Social Security? Either general revenues will have to be increased, or spending will have to be cut.

There are a number of alternative policy options for addressing the surplus/shortage problem. One choice would be simply to cut OASDI taxes in the coming decades, and encourage workers to save privately for their retirement—through tax favored IRA's for example—and reduce future Social Security benefits for those who do so. Alternatively, the Congress could choose to create a floating tax rate, which would increase or decrease in direct relation to expenditures. This method would conform to the pay-as-you-go model of financing. Another option would be to direct a portion of the surplus OASDI revenues to the Medicare (HI) trust fund, which is expected to face severe financing problems in the coming years.

(d) Long-term Deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The first part of this problem is that there are expected to be proportionately more older people, living longer, and continuing to retire early. Second, unusually high birth rates after World War II have already created a bulge in the population—the baby-boom generation—which is expected to reach retirement age beginning in 30 years. If life expectancy continues to rise and fertility rates stay low, as currently expected, the magnitude of this problem will be very great.

While the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily increase greatly over 1970's levels. Currently, Social Security benefits cost approximately 4.9 percent of the GNP. Under intermediate assumptions—with 1.5 percent real wage growth—Social Security is expected to rise to 6.47 percent of the GNP by 2030, declining to 6.12 percent by 2060.

By the same token, the relative increase in the number of beneficiaries per worker will not necessarily threaten the solvency of Social Security if productivity gains in the future compare to the experience of the past 30 years. If such gains continue, even though the ratio of workers to beneficiaries will probably decline, this could be offset by economic growth and increased real wages. However, many are highly skeptical about such a scenario.

In addition, this relative increase in beneficiaries will be a problem despite productivity increases, if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base, and might undermine the long-term solvency of the system.

Currently, neither short-term nor long-term deficits are projected for the OASDI trust funds. Although a wide variety of issues must be considered in the future, those issues will be best addressed once a clearer picture of what the future holds presents itself. However, it should be emphasized that Social Security is vulnerable to general economic conditions and should those conditions deteriorate, the Congress may need to revisit the financing of the system. Furthermore, Social Security may be subject to external political pressures to change its structure, notwithstanding its financial condition. Indeed, pressures to use the trust funds to reduce the Federal deficit may eventually forestall the maintenance of Social Security's internal solvency.

2. ISSUES

(A) SOCIAL SECURITY'S RELATION TO THE BUDGET

Since the late 1970's Social Security has repeatedly been discussed during budget deliberations. Many in Congress have been concerned that inclusion of the trust funds in the Federal budget resulted in a misleading picture of the Federal deficit. While the inclusion of Social Security shortages in the late 1970's inflated the apparent size of the deficit, the surpluses of the 1980's have served to reduce its evident magnitude. This phenomenon has led many to believe that the inclusion of the large Social Security surpluses projected for the coming years will disguise the enormity of the country's fiscal problems and diminish the pressure for deficit reduction.

In response, many advocates have proposed separating decisions about the operations of the Social Security program from the Federal budget process. As a major part of total Federal income and outlays, Social Security has stood out as a prime target for budget cutting proposals. Social Security cuts were made as part of the 1981 budget reconciliation bill and subsequent repeated proposals have been advanced to defer or freeze the annual cost-of-living adjustments (COLA's).

At the heart of this debate lie fundamental differences of perspective regarding the relation of Social Security to other Government programs. These include differences of opinion regarding: (1)

Whether the long range goals of Social Security, as opposed to many other Federal programs, justify its being exempted from immediate policy considerations; (2) whether it is possible to confront the Government's taxing and spending problems without including Social Security, which accounted for roughly 20 percent of Government outlays in fiscal 1987; (3) whether Social Security's separation from the budget process is merited due to its financation through a separate payroll tax; and (4) whether Social Security's inclusion results in confusion and complication of policy questions regarding its future, possibly meriting the program's being placed above politics.

The off-budget issue was partially resolved by the 1983 Social Security amendments and by the 1985 Gramm-Rudman-Hollings Act. The 1983 amendments required that Social Security be removed from the budget process by fiscal year 1993 and the subsequent Gramm-Rudman-Hollings law accelerated this removal to fiscal year 1986. It is important to note, however, that while Social Security benefits are off limits in the event of a Gramm-Rudman-Hollings budget sequester, administrative funds for SSA are not.

Under Gramm-Rudman-Hollings, the income and outlays of the Social Security program are to be excluded from budget documents, budget resolutions, and reconciliation legislation. However, this removal of the trust funds from the budget process has been less than total. Congress has merely created procedural hurdles to the consideration of altering Social Security benefits. The law now requires that during consideration of a budget resolution or reconciliation bill, separate votes modifying or suspending the rules are required by each legislative body in order to consider Social Security benefit changes.

Budgets have now been submitted which compare the Federal deficit both including and excluding Social Security. However, while the official budget excludes the Social Security trust funds, under Gramm-Rudman-Hollings, Social Security's annual surpluses or deficits are taken into account in the calculation of the deficit targets. Were it not for this inclusion, much deeper budget cuts would be required to reach the law's deficit reduction targets. Indeed, some estimates have shown that without the inclusion of Social Security in deficit calculations, additional cuts of up to $60 billion would be required to meet the Gramm-Rudman-Hollings target of a balanced budget by fiscal year 1991.

(B) ADMINISTRATIVE ISSUES IN SOCIAL SECURITY

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission—dignified, high quality service to the public. In the 1950's and 1960's, SSA was viewed as an elite agency, marked by high employee morale and excellent management. In the past 15 years, however, many have commented that the agency has lost its esprit de corps, and the quality of public service has declined. Factors cited as causing this decline include new agency responsibilities (for example, the creation of SSI in 1972), multiple administrative reorganization efforts, budget cuts and the fact that SSA has had 10 different Commissioners in the last 14 years. Many claim that public confidence in the agency has declined in recent years and that the agency has sacrificed the quality of service to the public in an effort to improve efficiency and cut costs.

These criticisms have resulted in numerous congressional requests for investigations of SSA problems. The outcome has been an ongoing review of the agency by the General Accounting Office (GAO). During the past several years, GAO has released a series of reports on SSA staff reductions and resulting quality of service provided to the public, payment accuracy to beneficiaries, accessibility to the agency by telephone, and problems of fragmented leadership.

In March 1987, GAO issued a comprehensive report entitled "Social Security Administration: Stable Leadership and Better Management Needed to Improve Effectiveness." The account analyzed a variety of administrative issues at the agency. According to GAO, while SSA has been attempting to accomplish administrative improvements, the agency has management difficulties which are not easily visible to the public. GAO reiterated long-standing concerns regarding the agency's constant state of flux due to repeated changes in leadership and recommended that the Congress legislate an 8-year fixed term for the Commissioner as a remedy.

An 8-year term was not viewed as a panacea for SSA's problems in their entirety, however. The additional problems cited by the study included SSA's lack of forward vision and planning. According to GAO's "Leadership" report, the agency "lacks a clear sense of how it wants to deliver services and checks in the year 2000." To improve SSA's planning, an Office of Strategic Planning (OSP) has now been created. According to SSA Commissioner Dorcas Hardy, the OSP's main task will be to develop a 10- to 15-year strategic plan to guide the agency's long-term development. Commissioner Hardy envisions the plan as integrating "all of SSA's areas of concern, including systems, operations, policy, data utilization, organizational structure, and staffing."

In addition to SSA's planning problems, GAO cited several long-standing agency inadequacies which remain unresolved. These problems include the issuance of deficient notices to beneficiaries, internal operating instructions and management information systems. It is beneficiary notices which most directly affect Social Security recipients.

Since notices provide much of SSA's contact with the public, their effectiveness is essential. SSA has frequently been criticized for the production of unclear and incorrect beneficiary notices. Inadequate notices create confusion, concern, and uncertainty among Social Security's millions of beneficiaries and simultaneously increase the workload for SSA employees. During the latter part of 1987, in an attempt to alleviate this problem, Commissioner Hardy unveiled a newly proposed information letter. If approved by OMB, the letter would, for the first time in history, provide future Social Security beneficiaries with an estimate of the monthly benefits they can expect to receive, well in advance of their retirement.

(1) Staff Reductions

Three 1987 GAO reports involved SSA staff reductions and service quality. Recent efforts by SSA to reduce its number of field offices and employees have raised concerns about a possible deterioration in the agency's quality of public service.

Staff levels at the end of March 1987 were 3 percent lower than at the end of fiscal year 1986. This decrease fell mostly on SSA's regional and field offices, which experienced a reduction of 1,896 employees. According to GAO, while key performance indicators for the agency continue to show stable overall performance, this is not the case for the Office of Hearings and Appeals (OHA). GAO found that as staffing at OHA decreased, processing times increased. However, GAO also pointed out that its sample was biased toward offices with alleged problems.

The philosophy guiding the SSA cuts was embodied in the 1983 Grace Commission Report, which recommended that SSA eliminate 17,000 staff positions and close over 800 field offices, based upon the rationale that operating a single large office in a city of 500,000 to 1 million would be cheaper than operating several small offices. Critics pointed out however, that the Grace Commission's rationale rested entirely on cost factors, and failed to assess the effect of closings on the quality of public service.

Indeed, in 1984, SSA was asked to provide OMB with an estimate of the staff-year savings which could result from an agency computer modernization plan. The agency was frought with disagreement regarding staff-reduction potentials and key persons were not involved in formulating the recommendation which eventually went forward. According to GAO, "it appears that SSA's inability to reach agreement and respond to requests * * * for staff-year savings and the resulting estimate * * * contributed to SSA's being in an essentially reactive position to OMB's call for a 17,000 staff reduction."

While most critics recognize that SSA must monitor its operating costs closely and that some staff reductions and office closings may be necessary, they nonetheless believe that SSA has been pursuing cost cuts without regard to the quality of service being provided. During a hearing of the House Ways and Means Subcommittee on Social Security, several parties testified that increasing workloads and the resulting deterioration of overall job effectiveness in some areas is contributing to severe stress among SSA employees. Critics cited the consequential loss of confidence in the system among younger workers, few of whom plan to make a career of Social Security. Moreover, many older workers state that their only reason for remaining with the agency is to keep their Civil Service retirement benefits. The combination of many employees fast approaching retirement age, along with the SSA's increasing difficulty in retaining a hiring pool of younger, lower level employees, threatens the future effectiveness of the agency. Dr. Arthur Flemming, former Secretary of the Department of Health, Education, and Welfare, believes this problem could have severe repercussions, especially given the rapid aging of the American work force. According to Dr. Flemming, morale problems within SSA are so severe that we stand to witness a deterioration in the caliber of SSA personnel at just the time when the burdens become heavier.

(2) Computer Modernization

Although SSA was once a leader in using automation to improve its operations, the last 10 to 15 years have seen its computer systems deteriorate to the brink of disaster. In the early 1980's, this deterioration affected virtually every aspect of SSA's operations, including its organization, management, personnel, and ability to serve the public. In the past decade SSA has made three attempts to upgrade its computer operations, none of which have been completely successful. The current effort, known as the Systems Modernization Plan (SMP), began in 1982. The SMP was to involve an effort to improve four major advanced data processing areas at the agency: (1) Software and software engineering; (2) hardware, and therefore SSA's capacity; (3) data communications utility; and, (4) database integration. The main thrust of this modernization effort was to involve software improvement.

While the SMP was originally designed as a 5-year modernization effort (1982–87), the project will probably not reach completion for several more years. While SSA originally estimated completion of the functional requirements of its redesigned computer by 1985, as of mid-1987 the agency estimated finalization in early 1988. Once those requirements are met, the design, testing, and implementation of the system will not be completed until some time in the 1990's. According to GAO, this will result in delaying much needed improvements in SSA's existing post-entitlement system.

It is important to note that SSA has made significant progress in certain areas of its modernization plan, including considerable hardware improvements and some software improvements. However, the agency has been criticized for hastily purchasing new hardware before its future needs were fully understood. In addition, crucial software modernization has been sluggish at best. According to GAO, the agency faces a difficult dilemma. During early 1987, GAO stated that SSA lacks sufficient personnel with the technical skills necessary to concurrently complete software modernization and maintain its present system. The most serious problem, however, involves SSA's lack of a long-term plan for service delivery. GAO believes that lack of such a plan could lead to an ineffective modernization effort. SSA could conceivably be locked into methods of providing services that may not be appropriate in the future.

The core of SSA's problems have consistently involved inefficient management and organization, as well as a lack of planning for the future. Efforts to improve these inadequacies will take time, especially when considering the continuing threat of administrative budget cuts. However, faced with continued congressional interest, SSA will likely continue to improve and modernize as efficiently as possible.

(3) SSA as an Independent Agency

Social Security's inclusion in the Federal budget beginning in the early 1970's magnified the visibility of its impact on national fiscal policy. The creation of the unified Federal budget sparked proposals for Social Security cutbacks by the Nixon, Ford, and Carter administrations. These propositions served as an incubator for a movement to create an independent Social Security agency. Calls for agency independence increased when, during the early 1980's, Social Security funds were repeatedly mentioned as a means toward balancing the Federal budget.

During the past two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services (DHHS). In its March 1981 recommendations, the National Commission on Social Security endorsed the establishment of an independent agency, as did a majority of the members of the 1983 National Commission on Social Security Reform. Many have recommended that a bipartisan board manage and oversee Social Security, as was the case in the first decade of the program—1935–46. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security to improve long-term management and effectiveness of the agency, and believe that independence is a means toward that end. They argue that Social Security, as an entitlement program, should be shielded from short-term partisan politics and bureaucratic infighting, and that administrative independence would enhance public confidence in the program.

The 1983 Social Security amendments, in keeping with the national commission's recommendation on agency independence, authorized the establishment of the Congressional Panel on Social Security Organization. The panel was instructed to identify an appropriate method for removing the SSA from HHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel's final recommendations to the Congress included the following:

> An independent SSA should be headed by a single Administrator, appointed by the President, with the advice and consent of the Senate, to a statutory 4-year term.
>
> The agency would have responsibility for the OASDI and SSI programs only, not Medicare or Medicaid.
>
> A permanent, bipartisan advisory board of nine members—five appointed by the President, two by the Senate, and two by the House—would oversee the program, and would make policy recommendations to the Administrator, the President, and the Congress.
>
> The new agency would be delegated certain administrative functions currently handled by the Office of Personnel Management (OPM) and the General Services Administration (GSA) to allow for greater operational flexibility.

In 1986, the House passed H.R. 5050, which contained a plan for an independent SSA. The bill was never reported out of the Senate Finance Committee. The House plan differed from the panel's in that it proposed a three-person, bipartisan board that would exercise SSA's rulemaking authority. The chief administrator of SSA would be responsible for operations of the agency and would be appointed by the President.

Both the panel and H.R. 5050 recommended including only Social Security and SSI in a separate agency. Medicare was not included. Opponents of including Medicare in an independent SSA point out that it would be operationally advantageous to have an agency that strictly handles cash benefits. They believe that incorporating Medicare which involves third-party intermediaries and an entirely different set of administrative tasks, greatly complicates the mission of an independent SSA. In the same sense that it is appropriate to link OASDI and SSI, it is reasonable to want to keep Medicare and Medicaid together, due to the overlap between the programs in clientele, structure, and purpose as public health care financing programs. If both Medicare and Medicaid were to be brought under SSA, it would leave DHHS with little responsibility. Some argue that SSA would then be an enormously complex, multi-program agency, with all the problems presently attendent upon DHHS.

A number of bills to establish an independent SSA have been introduced in the 100th Congress. Those proposals considered the most likely to receive attention include H.R. 1036, introduced by Representative Jacobs and S. 34, introducted by Senator Moynihan. While neither piece of legislation has yet come up for debate, members of the House Ways and Means Subcommittee on Social Security hope to see action on H.R. 1036 some time during the latter half of 1988.

While both above-mentioned proposals would establish an independent SSA, important aspects of both alternatives differ. The House bill, H.R. 1036, would place both the OASDI and SSI programs under the control of an independent agency. The Senate version, on the other hand, would also make the agency responsible for Medicare.

Sponsors of independent agency proposals often point out that since 1971, SSA has had nine different Commissioners and DHHS has had six different Secretaries. SSA has been administratively reorganized a number of times in the past decade, resulting in little continuity or long-term coherence in leadership and policy. Further, advocates point to major policy debacles that have plagued Social Security in the past 5 years, including the crisis in the DI program created by the overzealous implementation of continuing disability reviews, and the retroactive elimination, and subsequent restoration of the minimum benefit. It is contended that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security, and more effective in promoting sound policy and administration.

Many opponents of an independent SSA believe, however, that conflicts could arise between Board members that could impair the agency's efficiency. They point out that most agency problems do not result from SSA's location as a part of DHHS, but are rather the result of poor planning and policymaking. Organizational structure may be less to blame than bad leadership, low morale, and ill-considered and voluminous congressional legislation. Some claim that changing the administrative structure will not by itself eliminate policy problems. Improvements can only be accomplished by appointing intelligent and competent officials, and considering the potential administrative and statutory ramifications of their conributions. Opponents believe that while the creation of an independent SSA might alleviate certain management problems, it could just as easily create others. They maintain that SSA's current administrative problems have not resulted from bureaucratic obstacles imposed by DHHS, OPM, GSA, and the Office of Management and Budget, but rather that those agencies provide valuable oversight contributions, without which problems could be much worse. Arguments are also made that independence would not ensure elimination of the troublesome, frequent turnover of SSA Commissioners.

Many believe that Social Security's impact on the Federal fiscal policymaking agenda is too important to allow the program to escape difficult fiscal choices. They argue that an independent agency would not, and should not, put Social Security above politics and that an independent SSA would not exist in a political and philosophical void. A board appointed by the President and confirmed by the Senate would not necessarily be politically neutral, nor would a single administrator. It is precisely this type of political influence that advocates of an independent agency seek to avoid. They argue that independence would insulate Social Security programs from short-term fiscal policy decisions that could prove detrimental to the programs long-term efficiency. Others, however, assert that by establishing an independent tribunal with diminished accountability to the President, Social Security would be less accountable to the views of the public, and less subject to reform or revision should that become desirable in the future.

According to the General Accounting Office (GAO), the idea of an independent SSA presents both advantages and disadvantages. GAO believes that independence could enhance the stature of the Commissioner, thereby attracting highly qualified individuals to the job. Such conditions could indeed enhance policymaking and leadership continuity. However, GAO is troubled by the potentially detrimental effects of establishing a governing board. In supporting this position, the agency cites frequent criticisms of the effectiveness of similar boards, including: (1) Untimely decisions; (2) interference by board members in the daily operations of the agency; and (3) diffused accountability. GAO believes that confusion could develop regarding whether the President, the Commissioner, or the board would be accountable to Congress and the public. Although GAO declines to take a position on whether an independent agency is advisable, they do state that "on balance we do not believe that independence of SSA is essential to solving the serious management problems identified in our report. Independence is not the panacea."

(C) BENEFIT ISSUES AND LEGISLATIVE RESPONSES

Social Security has a complex system of determining benefit levels for the 37 million Americans who currently receive them, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes when it believed they were necessary. At present there are a number of specific issues related to the benefit structure that have drawn the attention of the Congress.

For nearly a decade prior to 1983, Social Security occupied the attention of the Congress primarily due to the threatened insolvency of the system. In 1983, the Congress enacted legislation that restored the financial health of the system's trust funds. This refinancing has caused Social Security to decline in urgency as an issue, although Congress has continued to take action affecting Social Security.

(1) The Social Security "Notch"

The Social Security "notch" is a difference in monthly Social Security benefits between those born in or prior to 1916, and those born in 1917 or later. The difference, which resulted from changes made by the 1977 Social Security amendments, is substantial only for those in the highest benefit levels who defer retirement until age 65. This problem became noticeable as individuals born in 1917 became age 65 in 1982.

The problem stems from a series of legislative changes made in the Social Security benefit formula, beginning over a decade ago. In 1972, the Congress enacted automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement. The intent was to eliminate the need for ad hoc benefit increases, and to fix benefit levels in relation to the economy. However, the method of indexing the formula was flawed in that initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the pre-retirement income of beneficiaries. Prior to the effective date of the 1972 amendments, Social Security replaced 38 percent of pre-retirement income for an average worker retiring at age 65. The error in the 1972 amendments, however, caused an escalation of the replacement rate to 55 percent for that same worker.

Without a change in the law, by the turn of the century, benefits would have exceeded a recipient's pre-retirement income. Financing this increase rather than reducing benefits would have entailed doubling the Social Security tax rate. This unpleasant situation provided a major impetus for the 1977 Social Security amendments, which substantially changed the benefit computation for those born after 1916. To remedy the problem, the Congress chose to partially scale back the increase in relative benefits for those born from 1917 to 1921 and finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high inflation in the late seventies and early eighties caused an exaggerated difference between the benefit levels of many of those born prior to 1917 and those born later.

Although the "notch" is actually the result of an over-indexation of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under transition rules, it has been perceived as a benefit reduction by those affected. In fact, while those born from 1917 to 1921 have been the most vocal supporters of a "correction," they fare much better than those born later. Individual Members of Congress have responded to the "notch-babies'" complaints by introducing a series of proposals for relief, most of which would give benefit increases to those born after 1916.

The two major "notch" bills introduced in the 100th Congress thus far include H.R. 1917, introduced by Representative Roybal and S. 1830, introduced by Senator Sanford. When, on October 29, 1987, Senator Sanford introduced the Social Security Notch Adjustment Act (S. 1830), Senator Melcher announced that the Special Committee on Aging would hold a hearing on the subject early in 1988. While much disagreement exists regarding the most advisable remedy for the "notch" situation, or even if one exists, interest in this issue persists.

The Social Security "notch" remains an inequity in the eyes of many people. Presidential candidates have already been repeatedly confronted regarding the "notch." It appears that no matter what people's opinions on the "notch" may be, it will remain an issue as long as a large number of Social Security recipients feel they are being cheated.

(2) A Consumer Price Index for the Elderly

The first Federal Consumer Price Index (CPI) was developed by the Shipbuilding Labor Adjustment Board during World War I. The purpose of this original CPI was to adjust wages during labor disputes, therefore leaving national defense production uninterrupted. Since that time, the CPI has undergone numerous modifications, resulting in the inflation index which is currently in place.

The present index, which represents the average U.S. inflation rate is computed using hundreds of components. The CPI's importance to older Americans is derived from its use in determining cost-of-living adjustments (COLA's) for Federal retirement programs. In 1972, Congress amended the Social Security Act to provide for automatic cost-of-living adjustments. When installing this new provision, the Congress chose to tie those COLA increases to changes in the CPI. It was believed that automatic increases would more effectively maintain the value of the retirement income of American retirees.

When automatic COLA's were first initiated, a single CPI was in existence. That index represented the prices of goods and services purchased by urban wage earners and clerical workers, and did not (and does not) survey retirees. In 1978 however, a new CPIu was created. The new index measured the goods and services purchased by all urban consumers, including white/blue collar workers, the unemployed, and retirees. Whereas the old CPI, redesignated as the CPIw, is representative of approximately 32 percent of the population, the CPIu is representative of about 80 percent.

While the CPIu includes a measure of the inflation experienced by the elderly, the CPIw does not. This has led many to argue that the CPIu, not the CPIw, should be tied to Social Security COLA's. The idea of an entirely separate index for the elderly did not appear until 1982. In March of that year, the National Commission on Social Security released its final report in which it discussed the need for a separate index. The Commission recommended that the Congress "authorize the necessary funds and personnel for the Bureau of Labor Statistics (BLS) to undertake the field surveys and analyses needed to determine how a special index for the elderly might be calculated and whether and to what extent it would be appropriate for adjusting the level of Social Security benefits for price increases for all Social Security beneficiaries."

In 1982, the GAO released a report on the subject. In its report, GAO recommended that COLA's be tied to the CPIu rather than the CPIw and, rather than use a CPIe (CPI for the elderly) for COLA's, BLS should publish a "hybrid retirees index" to "assure detection of major divergences in the cost-of-living for retirees." The Office of Management and Budget, however, opposed these recommendations due to cost and other considerations and they were never implemented.

A proposal by Senator Melcher for BLS to create a separate CPI for the elderly was added by unanimous vote to the Older Americans Act Amendments of 1987 (Public Law 100-175). While Senator Melcher's amendment stops short of tying the new CPI to Social Security COLA's, it does mandate that BLS produce an index which will provide an accurate picture of whether older Americans are treated fairly under the current system.

Supporters of the amendment cited studies which have shown that the inflation experienced by the elderly may be slightly higher than for the rest of the population. A 1982 study by Robert P. Hagemann found that food at home, fuel oil, natural gas, electricity, medical care services, hospital care, and insurance care of greater relative importance to retirees than for younger persons. Many of these findings were corroborated in a 1987 study by the staff of the House Budget Committee. The 1987 study found that retirees spend more on food, medical care, and fuel, and less on transportation and miscellaneous goods and services than the general public. The Committee also found that while food and energy prices fluctuate dramatically and erratically, the price of medical care rises relentlessly over inflation. This persistent rise in medical care costs appears to account for slightly higher inflation experienced by the elderly than by the general population and this excess may be expected to continue. Indeed, medical inflation in 1986 was five times higher than general inflation.

On June 29, 1987, the Senate Special Committee on Aging held a hearing into the creation of a retirees' CPI, at which Senator Melcher's amendment was discussed. The committee heard testimony from a variety of organizations regarding the importance of an accurate inflation measure with which to determine cost-of-living changes for older Americans. Supporters of a separate CPIe testified that they believed the impact of high medical inflation, as well as the cost of prescription drugs and other items heavily relied upon by older Americans, is not adequately reflected in the current CPI. They noted that the CPIw, currently used to determine COLA increases, does not cover a single retiree, but is primarily an index of middle and younger age groups. Supporters argued that even if a separate CPIe would result in only modest differences in COLA increases, such increases can be extremely important to older persons living on fixed incomes.

Opponents claimed that adequate data is not yet available for the construction of an accurate CPI for older Americans. They argued that creation of an accurate separate index would be costly and that the inflation rate experienced by the elderly does not appreciably differ from that of the general population. They did believe, however, that the inclusiveness of the CPIu may make it a more desirable index for the determination of Social Security COLA's than the presently used CPIw.

The Older Americans Act Amendments of 1987, which contained Senator Melcher's amendment to create a separate CPI for older Americans, were signed into law by the President on November 29, 1987 (Public Law 100–175). Senator Melcher's measure required that BLS produce a CPI for the elderly within 180 days of that date.

(3) Earnings Sharing

Social Security currently provides benefits to women either as covered workers or as dependent wives, widows, or ex-wives of covered workers. However, a woman cannot receive both benefits. Therefore, in the case of a one-earner couple, the Social Security benefit provided to a married couple is equal to 1½ times the benefit earned by the employed spouse. In the case of a two-earner couple, the Social Security benefit is based technically on their combined earnings record, but the lower earner's record is subsumed into the dependent spouse benefit, unless and until that record provides a larger benefit than the dependent spouse benefit.

This benefit structure was designed when less than 17 percent of married women worked outside of the home and the predominant family pattern was single-earner couples where the woman was the full-time homemaker and marriages were life long. Since mid-century, however, very different social patterns have emerged. The number of two-earner couples, for example, has risen dramatically, as has the number of marriages ending in divorce. Indeed, many of the presumptions upon which the Social Security system was built have changed.

Three distinct groups of women may be considered disadvantaged by the current Social Security system: (1) Divorcees, (2) two-earner couples, and (3) widows whose husbands die at an early age. First, widows whose husbands die early have often been the recipients of reduced benefits. These women's husbands incomplete earnings records often leave them with inadequate benefits. This problem can be exacerbated by many widow's choice to begin drawing actuarially reduced Social Security benefits at younger ages.

Second, divorcees are entitled to dependent's benefits based on their last marriage—of 10 or more years duration—and are disadvantaged in two respects. The working ex-spouse may decide to retire early, without consulting his ex-wife and her benefits as a dependent spouse will be reduced. More importantly, if the marriage does not last 10 years, a divorcee is not entitled to a dependent spouse benefit at all. Where women's work histories have been interrupted by unsuccessful marriages, an insubstantial earnings record and inadequate benefits are the inevitable result.

Finally, two-earner couples are disadvantaged by the current formula for determining benefits. Under present law, a two-earner couple whose combined earnings equal those of a one-earner couple. This is due both to the additional dependent-spouse benefit provided to the one-earner couple and to the fact that the base salary for determining the benefit of the two-earner couple will be the higher earner's salary unless and until the lower earner is entitled, on the basis of her own earnings record, to a benefit larger than that which she would be entitled to as a dependent of the higher earner.

Earnings sharing has emerged as the most popular proposal to address these equity and adequacy issues. However, while several bills have been introduced, none have yet received a great deal of consideration during the 100th Congress.

Under earnings sharing a couple's annual aggregate earnings would be divided equally between them for the purposes of computing a Social Security earnings record. Three notable developments would take place were earnings sharing to be implemented. First, the individual would be entitled to a Social Security benefit in his or her own right, thus removing any stigma of dependency attached to that benefit. Some argue that the change would merely recognize the value of a woman's work in the home. Second, it would allow divorced and widowed spouses to build on the earnings records amassed by their former spouses to improve their Social Security benefits. Finally, earnings sharing would remedy the present inequities between one- and two-earner couples whose identical aggregate income yields unequal Social Security benefits.

Studies by SSA and the Congressional Budget Office have shown that while earnings sharing would remedy the current inequities between one-earner and two-earner couples, it is far less effective at improving the adequacy of benefits received by older widowed and divorced women. Since Social Security currently provides a spousal benefit to a divorced spouse after 10 years of marriage—so long as she does not remarry—Social Security benefits based only on the income earned during the marriage might be significantly lower. Earnings sharing itself does nothing to remedy the problems of widows benefits under Social Security, except to encourage younger widows to add to the work record amassed by their spouses. To the extent that they do not, they will continue to receive inadequate benefits. While some earnings sharing proposals address this problem by guaranteeing at least current law benefits—the so-called no-loser bills—this adds tremendously to the implementation costs of earnings sharing.

Earnings sharing could receive attention in 1988. However, policy concerns such as the implementation costs, adequacy of benefits to divorced and widowed elderly, and the political impracticality of modifying Social Security so soon after the 1983 amendments will most likely continue to retard the progress of any such legislation.

(4) Social Security Earnings Test

An issue which promises to receive increasing attention over the coming year involves the elimination of the Social Security earnings test. In 1987, a Social Security recipient had his or her benefits reduced by $1 for every $2 he or she earned above $8,160. This benefit reduction is widely viewed as a disincentive to the continued employment of older workers. Indeed, many believe that the earnings test penalizes those aged 65 to 69 who wish to remain in the work force. Once workers reach age 70, they are not subject to the test.

The earnings test is among the least popular features of Social Security. Proponents of its elimination argue that while the test reduces Federal budget outlays, it also denies to the country valuable potential contributions of older, more experienced workers. Supporters add that no such limit exists when the additional income is from pensions, interest, dividends, or capital gains, and that it is unfair to single out those who wish to continue working. (For a breakdown of the income sources of older Americans, see chart 4 on page 8.)

Critics, however, point out that eliminating the earnings test will be extremely expensive. They find it difficult to justify draining the Federal budget by an additional $16 billion over 5 years in order to finance the test's immediate removal. Proponents, on the other hand, point out that older Americans who remain in the work force persist in making contributions to the national economy and continue paying Social Security taxes.

Given the high cost of eliminating the earnings test, it is likely that compromises will be made should a related proposal eventually be adopted. These could include proposals to phase the test's elimination over a period of several years, or to modify the earnings test for certain sectors of the population.

One such possible compromise involves farmers and other self-employed persons. It is widely acknowledged that farmers and other self-employed individuals are in positions different from the general population. Under present law, a farmer who loses money over a number of years and subsequently makes more in 1 year than the earnings test allows is penalized. Therefore, if total elimination of the earnings test seems unlikely, some may advocate requiring that SSA take recent years involving economic losses into account when testing the earnings of self-employed persons in a given year. Such a provision could require that SSA average 2 or 3 years of income together when testing the income of the self-employed. In essence, farmers and other self-employed individuals could offset their economic losses in 1 year with gains in another. Some estimates have shown that such an alternative would only cost $250 million over 5 years.

Should proposals for eliminating the earnings test gain momentum, however, such a compromise would probably not be needed. In this case, the most likely compromise would involve a slow phase-out of the test. The resulting total elimination of the earnings test would not only eliminate the inequities experienced by farmers and other self-employed individuals, but would eliminate a major disincentive for the continued employment of all older workers.

(5) 1988 Cost-of-Living Increase

Social Security cost-of-living adjustments are widely viewed as providing older Americans with crucial protection against inflation. The automatic COLA was instituted as a result of the 1972 amendments to the Social Security Act and was tied to changes in the CPI.

Effective January 1, 1988, Social Security beneficiaries received a 4.2 percent COLA increase, resulting from a more than tripling of inflation in 1987 over the 1986 level. The 1988 COLA hike is the largest since 1982, when beneficiaries received a 7.4 percent increase.

During October, SSA announced that beneficiaries would be eligible for a 4.2 percent COLA increase in 1988. Social Security and other Federal retirement program beneficiaries became fearful that they would not receive the scheduled increase, however, when congressional and White House negotiators began discussing budget balancing alternatives which included proposals to reduce or eliminate the 1988 COLA. Cutting COLA's for Federal retirement and Social Security would have saved approximately $5 billion during fiscal year 1988 and up to $12 billion the following year.

Proponents of limiting the 1988 increase argued for the necessity of including entitlements in budget cutting proposals if the Congress seriously intends to eliminate the deficit. Opponents argued that retirement program beneficiaries depend on the inflationary protection provided by COLA's to purchase necessities such as food, clothing, and heat. In the end, the scheduled increase became effective without reduction or delay.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. Background

In 1987, SSA continued the implementation of the extensive changes mandated by the Social Security Disability Reform Act of 1984 (Public Law 98-460). This legislation revised the standards and the process used by the SSA in reviewing the eligibility status of Disability Insurance (DI) beneficiaries.

Since the inception of the DI program, SSA has had the responsibility of continuously monitoring the eligibility of beneficiaries on the rolls. In response to the concern that SSA was not adequately reviewing eligibility, Congress included a requirement in the 1980 Social Security amendments that SSA review the eligibility of nonpermanently disabled beneficiaries at least once every 3 years. The purpose of the continuing disability reviews (CDR's) was to terminate benefits to recipients who were no longer disabled.

The new law was to go into effect in 1982. However, on its own initiative in early 1981, SSA accelerated the implementation of the reviews, increasing its monthly review workload by an additional 30,000 cases. As a result, between March 1981 and April 1984, 1.2 million case reviews were completed and close to 500,000 beneficiaries were determined no longer eligible for DI benefits.

Not long after the CDR's were implemented, widespread concern arose about the quality, accuracy, and fairness of the reviews. Many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDR's under guidelines that differed from SSA's official policy. By 1984, more than half the States were either not processing CDR's, or were doing so under modified standards.

In that same year, after extensive hearings and debate over numerous competing proposals, Congress enacted Public Law 98-460 to restore order, fairness, and national uniformity to the DI program. The main reform was to require that SSA prove a beneficiary's medical condition had improved from the time of the initial disability determination. Under that mandate, SSA promulgated three major sets of administrative regulations the following year. These rules created new standards for evaluating disabilities caused by mental impairments, created guidelines for the determination of medical improvement as a prerequisite to the termination of benefits, and revised the medical criteria applicable to the determination of a physical disability. Congressional committees continue to closely monitor the implementation of the new law, and a full evaluation of the impact of the reform measure is expected to be available by mid-1988.

2. Issues and Legislative Response

In contrast to the sweeping reforms enacted in the 1984 Social Security Disability Reform law and the subsequent flurry of regulatory activity to implement Public Law 98-460, recent congressional legislation has been relatively limited. Instead, the focus has largely been one of oversight, ensuring that the new law is carried out as effectively and fairly as possible.

Four major issues relating to the DI program gained congressional attention in 1987: (1) The effect of budget cuts on the DI program, (2) the expiration of the authority to grant benefits to disabled workers pending an appeal, (3) the adequacy of DI attorney fees, and (4) the length of the DI reentitlement period. In response, Congress passed legislation to address all but the first issue.

(A) EFFECT OF BUDGET CUTS

As part of the effort to reduce the administrative costs of the DI program, State offices responsible for reviewing disability cases were subject to both budget and staff cuts in fiscal year 1987. As a result, the total number of disability reviews fell by 262,000 over the previous year's level. According to an October 1987 report by the General Accounting Office, the annual cost to SSA in estimated unwarranted payments to beneficiaries was $200 million, or about three times the administrative expenses temporarily saved. To address this problem, GAO recommended that additional resources be provided to the State offices in order to process cases in which medical improvement could be expected. Congress can be expected to work closely with SSA to ensure that future decisions relating to the administrative budget of the DI program are not at the expense of overall savings in this area.

(B) EXTENSION OF INTERIM BENEFITS

Since 1983, a DI beneficiary who has been determined to be no longer disabled has been able to elect to continue receiving benefits, and thus medical care under Medicare, while appealing his or her case to an administrative law judge (ALJ). Each year, SSA reviews the cases of thousands of disabled workers. A significant number of these reviews yield adverse decisions, many of which are appealed and ultimately reversed. (In cases where the initial decision is upheld, cash benefits during the appeal are treated as overpayments and may be subject to recovery.) This provision was enacted in response to the fact that an appeal to an ALJ can take up to several months.

On December 31, 1987, the law authorizing interim payments during the appeals period was to expire. Thus, a decision to terminate benefits at the initial level was to take immediate effect, regardless of whether that decision was later ruled incorrect. Although back payments would be provided in such cases, the absence of benefits in the interim would pose a severe hardship on many disabled workers and their families.

Prior to the 1983 law authorizing interim payments, hundreds of thousands of disabled persons abruptly found themselves without any means of support or medical care as a result of the unprecedented number of DI terminations in the early eighties. Originally mandated for 1 year, in 1984, Congress extended the interim authority through 1987 as part of the reform law. By the end of that period, it was assumed, the abuses that were rampant at that time would be eliminated.

In 1988, over 215,000 cases—8 percent of the total number of DI beneficiaries—are expected to come under review. Based on past termination rates, approximately 51,000 cases will be deemed ineligible. About 41,000 of these decisions will likely be challenged, with about half of those ultimately being reversed. Thus, without an extension of the law, in 1 year alone benefits could be unfairly denied 20,000 disabled workers and 40,000 of their dependents.

Following notice from the Secretary of the Department of Health and Human Services (DHHS) of the imminent lapse of the law, Congress acted swiftly in the final days of 1987 to extend the interim authority through 1988. This legislation was included in the Omnibus Budget Reconciliation Act of 1987, enacted on December 22, 1987, as Public Law 100-203. The question of any future extensions was postponed in anticipation of a DHHS study on the interim-payment program, which is expected to be available by mid-1988.

(C) ATTORNEY FEES

From the standpoint of the disabled worker, severe mental or physical conditions can make a complex adjudicative process especially intimidating and confusing. Not surprisingly, disability claimants are increasingly turning to attorneys for assistance. In 1987, approximately 60 percent of cases that were challenged had legal representation.

Payment for the services of an attorney in such cases is taken from the past due benefits awarded to successful claimants. Under law, compensation is the smaller of 25 percent of the retroactive benefits, the amount agreed upon between the attorney and the client, or the amount set by SSA.

On April 1, 1987, administrative law judges temporarily lost the authority to approve fee requests above $1,500 as a result of a new SSA policy. Previously, the maximum amount such judges could approve was double that amount—$3,000. A fee petition above

$1,500 required approval by a regional authority. The basis for this action, according to SSA, was a report of the Inspector General, which concluded that attorney fees were frequently excessive and should be lowered to a set rate.

Following the start of the new policy, many DI attorneys protested that the new policy would deny them adequate compensation, and that payments would be further delayed and complicated as a result of the additional layer of bureaucracy. Moreover, it was argued, disability claimants would be the ultimate losers because fewer and fewer attorneys would be willing to represent them.

Underlying the issue of DI attorney fees is the challenge of ensuring adequate safeguards against overcharges while providing fair compensation for services performed on behalf of the claimant. The only point which disability attorneys and SSA agree upon is that the original payment system is cumbersome, drawn out, and in need of reform.

Opposition to the new SSA policy rapidly intensified, along with concern over the potential adverse impact on beneficiary representation. In late 1987, Congress thus enacted legislation in the reconciliation measure (Public Law 100–203) to rescind the new SSA directive and impose a moratorium until mid-1989 on changes to the original payment policy pending the completion and consideration of studies by SSA and GAO. Both studies are expected by mid-1988.

(D) EXTENSION OF THE AUTOMATIC REINSTATEMENT PERIOD

Under the DI trial-work program, a disabled beneficiary may work 9 months without risking the loss of benefits and Medicare coverage. If earnings exceed substantial gainful activity (SGA)—$300 per month—cash benefits are discontinued on the 12th month, followed by termination of medical coverage 2 years later. For an extended time thereafter, if the disabled person fails in this effort, he or she will be automatically reentitled to receive DI benefits.

As a result of legislation enacted in the 1987 reconciliation measure (Public Law 100–203), the automatic reentitlement period was extended from 15 months to 36 months, following the cut-off date of cash benefits. The period of Medicare eligibility remains unchanged. This extension helps to reduce a major disincentive toward work in the DI program.

C. PROGNOSIS

In the near term, Social Security policy is likely to remain fairly stable, with few significant issues demanding the attention of the Congress. The 1983 changes in Social Security financing have for the most part guaranteed the solvency of the system and reduced the pressure on Congress to legislate changes in the program to improve its financing. The removal of Social Security from the unified budget will also provide some insulation from program cuts. In addition, the Gramm-Rudman-Hollings Act specifically excludes Social Security benefits from the effect of automatic spending cuts.

However, the drastic nature of the cuts mandated by the Gramm-Rudman-Hollings Act also indicates the degree to which Congress is concerned about the growth of the Federal deficit, and this concern may eventually affect Social Security. While tax increases might shrink the deficit to some degree, additional spending cuts will be required to balance the Federal budget. It is possible that, in an attempt to avoid cutting funding for certain strained program areas, the option of delaying or cancelling some future Social Security COLA's will become more appealing. In the midst of the budget debate, however, will be discussions on the costly elimination of the Social Security earnings test and other perceived inequities in the Social Security program.

Regarding the DI program, it appears clear that the 1984 reforms brought to a halt the extensive and abusive administrative practices in the continuing disability review process of the early eighties. A more complete and accurate picture should emerge in 1988, when a thorough assessment of the impact of the law is expected. Attention will likely focus on the degree of evidence necessary to establish medical improvement, and the general stringency or leniency with which the new rules are being applied.

In future budget deliberations, the Congress must weigh carefully short-term administrative cuts against overall savings in the DI program. In 1988, the Congress will face again the issues of the adequacy of DI attorney fees and the future of the law authorizing interim benefits to DI claimants. Recent congressional actions were not intended to achieve long-term resolution, but rather to extend the status quo pending the completion of studies in both of these areas.

As in the past, congressional and administrative actions affecting the DI program can be expected to take pendulum-like swings. Thus, after moving to assure that the SSA is not arbitrarily denying benefits to those who meet eligibility requirements and are in desperate need of assistance, the Congress is likely to respond to critics who inevitably point to abuses of the system. The challenge facing the Congress and the SSA is to strike a balance which addresses fairly and effectively both of these vital concerns.

In the long term, the payroll tax increases scheduled for 1988 and 1990, will result in accelerated accumulation of annual OASDI trust fund surpluses. As wage earners feel the effects of these tax increases, however, pressure may mount to defer or reduce them. Given the changing demographics of the U.S. population and the enormous effect of Social Security on the economy, further Social Security reforms will probably be necessary in the distant future. However, given the program's current solvency and the projected buildup in program assets, major reforms which significantly alter the program are unlikely to occur for some time to come.

Despite the efforts of some to discredit the Social Security system, the program retains the overwhelming support of the general public, the elderly, and the Congress. Given this support and the projected long-term solvency of the trust funds, Social Security may be expected to continue effectively meeting the challenges it will inevitably confront in the future.

Chapter 3

EMPLOYEE PENSIONS

OVERVIEW

Many employees receive retirement income from sources other than Social Security. Numerous pension plans are made available to employees by a variety of employers, including companies, unions, Federal, State, and local governments, the U.S. military, National Guard, and Reserve forces. The importance of the income these plans provide to retirees accounts for the notable level of congressional interest throughout recent years, culminating in massive pension reforms during 1986.

Largely because 1986 had been such a monumental year for the improvement of pension plans and benefits, Congress was disinterested in legislating further pension alterations in most areas during 1987. Indeed, by the end of 1986, most of the major retirement income policy issues that were debated in recent years had been either fully or partially resolved by legislation. However, there were some exceptions.

Among the more notable changes to occur during 1987 was a near doubling of the insurance premium charged to employers by the Federal Government's pension insurance agency, the Pension Benefit Guarantee Corporation (PBGC). In recent years, the PBGC has been nursing an ever-swelling deficit and the establishment of an adequate variable rate premium was widely viewed as a crucial remedy.

Issues surrounding overfunded and underfunded pensions also received attention during 1987. Near the end of the first session of the 100th Congress, many organizations and congressional representatives fought for new legislation to require that employers who withdraw fund assets from overfunded plans share the spoils with their employees, however these efforts were unsuccessful.

The most important event of the year to affect pension plans occurred on October 19, 1987, when the Dow Jones Industrial Average plummeted an historic 508 points, losing nearly a quarter of its total value in a single day. During the month of October, the Nation's pension funds experienced the disappearance of $210 billion in assets—a loss to portfolios of nearly 10 percent. While the 41 million workers covered by approximately 216,000 defined-benefit plans were given little more to worry about after the crash than had previously been the case, the 33 million employees covered by 533,000 defined-contribution plans have suffered at least a temporary reduction in retirement security.

A. PRIVATE PENSIONS

1. Background

Employer-sponsored pension plans provide many retirees with a needed supplement to their Social Security income. Most of these plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. However, 17 percent of all private plan participants are covered by multiemployer plans which provide members of a union with continued benefit accrual while working for any of a number of employers within the same industry and/or region. According to a September 1987 report by the Bureau of the Census, 67.1 percent (52.7 million) of all wage and salary workers were covered by an employer-sponsored pension plan in 1984. Census found that employees of larger firms were far more likely to be covered by an employer-sponsored pension plan than were employees of small firms. While business and repair service, retail trade, agricultural, and personal service workers received a low rate of pension coverage, more than 70 percent of those employed by public utilities, professional and related services, and the manufacturing and mining industries were covered by a plan. As of 1985, private pension funds totaled $917 billion and accounted for 42 percent of the institutional assets in the economy. In 1986, Federal tax expenditures for public and private employer-sponsored pensions cost the Government $71 billion.

Most private plan participants are covered under a defined-benefit pension plan. The remainder participate in defined-contribution pension plans. Defined-benefit plans specify the benefits that will be paid in retirement, usually as a function of the worker's years of service under the plan or years of service and pay. The employer makes annual contributions to the pension trust based on estimates of the amount of investment needed to pay future benefits.

Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on a combination of his or her pay and length of service. Fewer than a third of all participants in medium and large size private plans receive benefits based on a fixed dollar amount for each year of service. Most fixed dollar plans cover union or hourly employees and are collectively bargained between the union and employer. The majority of pension plan participants are in salary-related plans that base the benefit on a fixed percentage of career average pay or final 3 or 5 years pay.

Workers in private-sector defined benefit plans are typically in large primary pension plans funded entirely by the employer. More than three-quarters of the participants in defined-benefit plans are in plans with more than 1,000 participants. The largest employers generally supplement their defined-benefit plan with one or more defined-contribution plans. Where supplemental plans occur, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, fewer than 3 percent of the contributions to defined-benefit plans come from employees. Most of those contributing to their pension plans are government employees.

Defined-contribution plans, on the other hand, specify only a rate at which annual or periodic contributions are made to an account. Benefits are not specified but are a function of the account balance, including interest, at the time of retirement. Defined-contribution schemes are not strictly "pension plans," in that they are not all intended solely to provide retirement income. However, they are all included in ERISA and Internal Revenue Code definitions of plans subject to tax qualificiations and fiduciary requirements.

Private pensions are provided voluntarily by employers. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers deduct their current contributions even though they do not provide immediate compensation for employees; (2) income earned by the trust fund is tax-free; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantage, however, is the tax-free accumulation of trust interest (inside build-up) and the fact that the benefits are usually taxed at a lower rate than contributions.

In the last decade the Congress has increasingly used special tax treatment as leverage to enforce widespread coverage and benefit receipt. In the Employee Retirement Income Security Act (ERISA) of 1974, Congress first established minimum standards for pension plans to ensure broad distribution of benefits and limited pension benefits for the highly paid. ERISA also established standards for funding and administering pension trusts, and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

In 1982, Congress sought in the Tax Equity and Fiscal Responsibility Act (TEFRA) to prevent discrimination in small corporations by requiring so-called "top heavy" plans (i.e.: plans in which the majority of plan assets benefit "key" employees) to accelerate vesting and provide a minimum benefit for short-service workers.

In 1984, Congress enacted the Retirement Equity Act (REA) to improve the delivery of pension benefits to workers and their spouses. REA lowered minimum ages for participation to 21, provided survivor benefits to spouses of vested workers, and clarified the division of benefits in a divorce.

Title XI of the Tax Reform Act of 1986 made major changes in pension and deferred compensation plans in four general areas: (1) Limitations on tax-favored voluntary savings; (2) reform of coverage, vesting, and nondiscrimination rules; (3) changes in the rules governing distribution of benefits; and (4) modifications in limits on the maximum amount of benefits and contributions in tax-favored plans.

2. ISSUES AND LEGISLATIVE RESPONSES

(A) BENEFIT ADEQUACY

The objective of retirement plans is to replace workers' preretirement earnings with sufficient benefits to maintain their standard of living during retirement. In 1981, the President's Commission on Pension Policy recommended that to achieve this goal, the average wage earner would need income from pensions, Social Security, and other sources equal to approximately 75 percent of preretirement earnings. The Commission also recommended that "replacement ratios" for low-wage earners should be higher than for high-wage earners.

Because Social Security provides a higher replacement ratio to low earnings workers (25 percent), pensions often tilt their benefits the other way—providing a higher replacement to the higher paid. For example, a plan for a minimum wage worker receiving 54 percent of preretirement earnings from Social Security would only need to replace 20 to 35 percent of that person's preretirement earnings to meet a goal of 75 percent replacement. On the other hand, a worker paying the maximum Social Security tax (with 25 percent replacement from Social Security) would need to replace an additional 50 percent of preretirement earnings to meet that same ratio.

According to the Bureau of the Census, of all retirees receiving pension benefits in 1984, 66.4 percent were men. While the mean monthly pension income of male retirees was approximately $670, pension income for women was about $370 per month. The Census Bureau found that retirees under age 65 received higher pension income than those above age 65. Older retirees, however, were far more likely to be receiving Social Security benefits concurrently with their pensions.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The Department of Labor has found that the median benefit for workers with 10 years of service under their last pension plan replaced only 6 percent of their preretirement income while the median benefit of those with 35 years of service replaced 37 percent of preretirement income. Similarly, workers who entered the plan at a young age accumulated larger pensions than those who entered the plan late in life.

(1) Coverage

In 1984, 67 percent of all wage and salary workers were covered by an employer-sponsored pension plan. While the coverage rate for workers with monthly earnings below $500 was only 37.8 percent, 84 percent of those earning $2,000 or more each month were covered by a pension.

Employers who offer pension plans do not have to cover each of their employees. The law governing pensions—ERISA—permits employers to exclude part-time, newly hired, and very young workers from the pension plan. In addition, the law has required employers to cover, at most, only 70 percent of the remaining workers (only 56 percent if employees must contribute to participate in the plan); and an even smaller percentage of workers if the classification of workers the plan excludes does not result in the plan discriminating in favor of the highly paid.

The 1986 Tax Reform Act increased the minimum requirements for the proportion of an employer's work force that must be covered under company pension plans. Under prior law, a plan (or several comparable plans provided by the same employer) had to meet either a "percentage test" or a "classification test" to be qualified for deferral of Federal income taxes. Employers who were unwilling to meet the straightforward percentage test found substantial latitude under the classification test to exclude large percentages of lower paid workers from participating in the pension plan. Under the percentage test, the plan(s) had to benefit 70 percent of the workers meeting minimum age and service requirements (56 percent of the workers if the plan made participation contingent upon employee contributions). A plan could avoid having to meet this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. Classifications actually approved by the Internal Revenue Service, however, permitted employers to structure plans benefiting almost exclusively highly compensated employees.

Pension coverage was expanded in the Tax Reform Act by raising the percentage of employees that must be covered under the percentage test, and by eliminating the classification test and replacing it with much tougher and more specific alternative tests: A "ratio test" and an "average benefit test". Under the new percentage test, 70 percent of nonhighly compensated workers must benefit (as opposed to 70 percent of all workers). Alternatively, an employer can benefit a smaller percentage of the company's work force if the number of nonhighly compensated workers benefiting is at least 70 percent of the number of highly compensated workers. The average benefit test permits employers to adjust the coverage requirements to take into account the level of benefits in the plan. Employers can meet this test by providing nonhighly compensated employees, on average, at least 70 percent of the average benefit of highly compensated employees (counting noncovered employees as having zero benefits). Plans are required to meet these new coverage requirements by January 1, 1989.

Most noncovered workers, however, work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms tend not to provide pensions because a pension plan can be administratively complex and costly, often these firms have low profit margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projected trends in future pension coverage have been hotly debated. The expansion of pension coverage has been slowing steadily over the last few decades. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. In recent years, coverage has actually declined slightly due to recession, job loss in the well-covered manufacturing sector and job expansion in the poorly covered service sector. It is unlikely that pension coverage will grow much without some added incentive for small business to add pension plans and for employers to include currently excluded workers in their plans.

(2) Vesting

Simply because a worker may be covered by a pension plan does not insure that he or she will receive retirement benefits. To receive retirement benefits, a worker must vest under the company plan. Vesting entails remaining with a firm for a requisite number of years and therefore earning the right to receive a pension.

Vesting provisions are a simple way to insure that benefits do not go to short-term workers, as well as to induce certain workers to remain on the job. Indeed, those employees who are only a few years short of vesting tend to remain on the job until they are assured of receiving a retirement benefit.

Most workers today do not stay with the same employer the number of years required to vest in their pension plans. ERISA standards have required that plans which vest no benefits during the first 10 years of employment fully vest those benefits after 10 years of employee service. Due to declining job tenure, today's workers are having more difficulty earning pensions than did their predecessors. The average job tenure for a male aged 40–44, for example, has dropped from 9.5 years in 1966 to 8 years in 1981. Women's average job tenures are declining less rapidly—but already tend to be much shorter than those of men. Job tenure for women aged 40–44 dropped from 4.1 years in 1966 to 3.9 years in 1981.

To enable more employees to either partially or fully vest in a pension plan, the 1986 Tax Reform Act required more rapid vesting than in the past. The new provisions, which apply to all employees working as of January 1, 1989, will require that if no part of a benefit is vested prior to 5 years of employee service, then benefits must be fully vested at the end of 5 years. If a plan provides for vesting of 20 percent of the benefit after 3 years, then full vesting is required at the end of 7 years of service.

(3) Benefit Distribution and Deferrals

Vested workers who leave an employer before retirement usually have the right to receive vested deferred benefits from the plan when they reach retirement age. Benefits that can only be paid this way are not portable in that the departing worker may not transfer the benefits to his or her next plan or to a savings account. Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits.

Federal policy regarding lump-sum distributions has been inconsistent. On the one hand, Congress formerly encouraged lump-sum distributions by permitting employers to make mandatory distributions without the consent of the employee on amounts of $3,500 or less; and by providing favorable tax treatment through the use of the unique "10-year forward averaging" rule (permitting the tax payment to be calculated as though the individual had no other income). On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account (IRA) within 60 days.

IRA rollovers, however, appear to have been largely ineffective. To the extent that workers receive lump-sum distributions, they tend to spend them rather than save them; thus distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lump-sum distributions are saved in a retirement account and only 32 percent are retained in any form. Even among older and more educated workers, fewer than half roll their preretirement distributions into a retirement savings account.

How and when a plan distributes to employees is a key factor in that plan's ability to deliver adequate retirement benefits. Even if a worker is vested, he or she may lose pension benefits under some plans upon changing jobs. This benefit loss results from differences in how some plans accrue benefits.

Final-pay formulas have been popular with employers because they relate the pension benefit to the worker's earnings immediately preceding retirement. However, final-pay plans penalize workers who leave the plan before retirement by freezing benefits at the last pay level under the plan. Workers who are years from retirement will often be entitled to pension benefits of little value. Therefore, a mobile worker earning benefits under several final-pay plans will receive much lower benefits than a steady worker who spends a full career under a single plan.

Traditionally, different types of plans have distributed their benefits in different forms. Defined-benefit pension plans have generally provided distributions only in the form of an annuity at retirement, while defined-contribution pension, profit-sharing, or thrift plans have generally provided distributions as a lump-sum payment whenever an employee leaves the company. Current tax law provides special tax treatment for lump-sum distributions—both under the IRA rollover rules if they are saved in a retirement account and under the 10-year forward averaging and capital gains rules without regard to how they are used.

Current policy regarding distributions is often criticized for encouraging the consumption of preretirement distributions and the loss of retirement savings. While not all employer plans are designed solely to provide retirement income, many of those that are provided lump-sum distributions for many circumstances other than retirement.

The Tax Reform Act of 1986 established substantial disincentives to use pension or deferred compensation plan accruals for any purpose other than providing a stream of retirement income. It imposes an excise tax of 10 percent on distributions from a qualified plan before age 59½, other than those: Taken as a life annuity, taken upon the death of the employee, taken upon early retirement at or after age 55, or used to pay medical expenses. Additionally, the act repeals the special tax treatment for lump-sum distributions which has been permitted under the 10-year forward-averaging and capital gains rules. Finally, the bill modifies the tax treatment of distributions from plans with after-tax employee contributions. Under prior law, previously taxed employee contributions could be recoverd tax-free from a pension or deferred compensation plan before taxes are applied to any remaining amount. Tax reform repealed the provisions permitting an initial recovery of previously taxed contributions and requires that taxes be paid on a pro rata share of the total benefit not attributable to previously taxed contributions.

(4) Pension Integration

Current rules permitting employers to reduce pension benefits to account for Social Security benefits can result in an excessive reduction or even elimination of lower paid workers' pension benefits. Under the Social Security program, employees generally pay a uniform tax rate but receive Social Security benefits that are proportionately higher at lower levels of income. Employers who want to blend their pension benefits with Social Security benefits to achieve a more uniform rate of income replacement for their retirees use integration to accomplish this goal. The integration rules define the amount of adjustment a plan can make to pension benefits before the plan is considered discriminatory.

In general, two types of integration exist—excess and offset. In excess integration, plans pay a higher contribution or benefit on earnings above a particular level (the "integration level") than they pay on earnings below that level; current rules permit plans to make no contributions below the integration level. In offset integration, plans reduce the pension benefit by a percentage of the Social Security benefit, which can result in the elimination of an individual's entire pension.

In the past, pension integration could be used unfairly, thus depriving workers of legitimate benefits. Internal Revenue Service rulings permitted a defined-contribution plan to provide contributions on pay above the Social Security wage base ($42,000 in 1986) at a rate 5.7 percent higher than those provided on pay below the wage base. Plans could provide no contributions on pay below the wage base if the contribution rate above the wage base was 5.7 percent or less. The rulings permitted a defined-benefit plan to meet either an excess plan or an offset plan rule. In the excess plan, the difference in benefits as a percentage of final earnings paid above and below the average Social Security wage base could not exceed 37.5 percent. In the offset plan, the final pension benefit could be reduced by an amount equal to 83.3 percent of the Social Security benefit. In practice, pension benefits were often eliminated for workers with low wages.

Tax reform modified the amount of integration permissable under the revenue rulings to prevent the elimination of pension benefits. Under the new integration rules, participants receive a minimum of 50 percent of the pension benefit they would receive without integration. Defined-contribution plans cannot contribute above the wage base at a rate more than twice the rate they contribute below the wage base and in no case can they have a differential greater than that under prior law (5.7 percent). Excess plans cannot pay benefits on final pay above the wage base at a rate exceeding twice the rate they pay below the wage base, nor can they have a differential in the rate exceeding three-fourths of a percent times years of service. Offset plans cannot pay less than 50 percent of the pension benefit that would have been paid without integration and in no case can they reduce the pension by more than three-fourths of a percent of the participant's final average pay multiplied by years of service. The new integration rules apply to contributions or benefits after January 1, 1989.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, estimated by the Treasury to equal $53 billion in 1986. In return, Congress regulates private plans to prevent overaccumulation of benefits by the highly paid. Efforts to prevent discriminatory provision of benefits have focused on the potential for discrimination in voluntary savings plans and on the effectiveness of current coverage and discrimination rules.

In recent years, there has been a substantial increase in tax-free individual contributions to retirement and savings plans. Prior to 1974, only employees of public or tax-exempt organizations could elect to defer a portion of their salary without paying income taxes on it through a tax-sheltered annuity (TSA) as established under section 403(b) of the Internal Revenue Code. Private sector employees could make only after-tax contributions to a retirement plan. Beginning in 1974, the Congress gradually extended the opportunity to make tax-free elective deferrals to all employees. Legislation was enacted in 1974 permitting workers not covered by an employer-sponsored pension plan to defer up to $2,000 a year to an individual retirement account (IRA). Then, in 1978, cash or deferred arrangements (CODA's) were authorized for private employers under section 401(k). Workers covered under a CODA may make elective tax-free contributions (by agreeing with the employer to reduce their salaries) to an employer plan. The amount that any worker could contribute was limited by the total limit on all pension contributions (25 percent of salary up to $30,000) and by a separate nondiscrimination test for 401(k) plans restricting the average percentage of salary deferred by highly paid workers to 150 percent of the average percentage of salary deferred by lower paid workers. Finally, in 1981 Congress opened up the opportunity to defer $2,000 a year in an IRA to all workers.

Concern has grown in recent years that tax-free voluntary savings may offer too great a tax shelter for the highly paid and may be inequitable. The tax benefits of voluntary savings are most attractive to those in the highest tax brackets. While a large portion of the tax benefit goes to those who would probably save for retirement without it, many who need the retirement savings do not benefit from the tax provisions. In addition, there is some concern that the aggregate tax expenditures to encourage savings have become excessive. For example, the majority of those using IRA's in the past were also participating in a corporate pension or 401(k) plan.

Nondiscrimination rules are intended to ensure that employee benefit plans that are tax-favored are of benefit to a broad cross-section of employees and not just the highly paid. Corporate pension and deferred compensation plans are required to meet a number of nondiscrimination tests for coverage and comparability of benefits as set forth in sections 401 and 410 of the Internal Revenue Code (and various revenue rulings) to become tax-qualified. Plans are required to benefit either 70 percent of the employees who meet age and service requirements (56 percent in a contributory plan) or a classification of employees that the Secretary of the Treasury finds not to be discriminatory. Benefits provided in one or a number of plans by the same employer must be reasonably comparable (in relation to pay) at various pay levels.

CODA's, in which participation is optional for the employee, must meet an additional nondiscrimination test based on the use of the plan, to ensure that the highly paid are not benefiting disproportionately from the plan. Under current law, the top one-third of employees, by pay, cannot defer more than 1.5 times the average proportion of salary that the lower paid two-thirds actually defer.

In the last few years, there has been growing concern that the current coverage rules are too loosely structured and have been weakened too much through revenue rulings to ensure broad participation in employer plans by lower paid workers. In addition, there has been some concern that the current CODA discrimination rules permit excessive deferrals by the highly paid in relation to the amounts actually deferred by the lower paid. Tax-sheltered annuities have not been exempt from nondiscrimination requirements for tax qualified plans since these were established under a separate section 403(b).

(1) Limitations on Tax-favored Voluntary Savings

The Tax Reform Act tightened the limits on voluntary tax-favored savings plans in an effort to target limited tax resources where they can be most effective in producing retirement benefits. The act repeals the deductibility of contributions to an IRA for participants in pension plans with adjusted gross incomes (AGI's) in excess of $35,000 (individual) or $50,000 (joint)—with a phased-out reduction in the amount deductible for those with AGI's within $10,000 below these levels. It also reduces the dollar limit on the amount employees can elect to contribute through salary reduction to an employer plan from $30,000 to $7,000 per year for private sector 401(k) plans, and to $9,500 per year for public sector and nonprofit 403(b) plans. Additionally, the act tightens the nondiscrimination test that further limits the elective contributions of highly compensated employees in relation to the actual contributions of lower paid employees. Finally, the act encourages small employer adoption of pension plans by permitting employers with fewer than 25 employees to adopt simplified employer pensions (SEP's) with elective employee deferrals.

(2) Limitations on Benefits and Contributions

The amount of additional accumulation an individual can have each year in a tax-favored plan is limited under section 415 of the Internal Revenue Code. Under prior law, the annual benefit payable from a defined-benefit plan could not exceed 100 percent of an individual's compensation (up to a maximum benefit of $90,000). The annual contribution made to a defined-contribution plan could not exceed 25 percent of compensation (up to a maximum of

$30,000). If an employee participates in both defined-benefit and defined-contribution plans, their total accumulation is subject to a combined limit. Although the dollar limits are currently frozen, beginning in 1988 they will be indexed for post-1986 cost-of-living increases.

In recent years, the Congress has reduced and frozen the section 415 limits largely in an effort to raise revenue for the Federal Government in the context of deficit reduction. The Tax Reform Act restores the indexing of the section 415 limits, modifies the relationship between the benefit and contribution amounts to establish parity, and changes the adjustment in the defined-benefit dollar limit for early retirement. The defined-benefit limit would be indexed for inflation beginning in 1987, while the defined-contribution limit would remain frozen until the defined-benefit limit is four times as great—a ratio of contributions to benefits that is believed to result in roughly equal retirement benefits. Once the four-to-one ratio is reached, both limits would be indexed. Although, the defined-benefit limit remains the same for benefits commencing at age 65, the Tax Reform Act requires full actuarial reduction for benefits paid at earlier ages—so that the maximum annual benefit for someone retiring at age 55 is reduced from the current floor of $75,000 to $40,000.

To reduce the potential for an individual to overaccumulate by using several plans, the Tax Reform Act both retains the current law combined limit and adds a 15 percent excise tax to recapture the tax benefits of annual benefits (including IRA withdrawals) in excess of 125 percent of the defined-benefit limit (but not less than $150,000).

One of the major purposes of the retirement provisions of the Tax Reform Act of 1986 is to expand the proportion of the population receiving pension benefits and raise average benefits from employer-sponsored plans. Data prepared by ICF, Inc., for the American Association of Retired Persons (AARP) indicates that the combination of expanded coverage, 5-year vesting, limits on pension integration, and tighter distribution rules is expected to substantially increase future benefits paid to today's younger workers. The study simulated the pension income received by the families of workers who will reach age 67 in the years 2011–2020. The benefit improvements in the Tax Reform Act will raise average annual family pension income from $8,400 (under prior law) to $10,200 (1986 dollars) and will increase the percentage of families receiving pension income from 68 percent (under prior law) to 77 percent. Women, in particular, are expected to benefit from the pension reforms. ICF estimated that the Tax Reform Act changes will increase the number of women with pension benefits during the 2011–2020 period by 23 percent.

(C) PENSION FUNDING

The contributions plan sponsors set aside in pension trust are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 (ERISA), regulates the level of funding and the management and investment of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined-benefit plans) must either have assets adequate to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Plans created since 1974 must reach full funding within 30 years. Plans predating ERISA are allowed 40 years to develop full funding. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," and prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined-benefit plans. This program guaranteed benefits up to $1,858 a month in 1987 (adjusted annually). As of 1986, the single-employer program was funded through annual premiums of $8.50 per participant paid by employers to a nonprofit Government corporation—the Pension Benefit Guaranty Corporation (PBGC). When an employer terminated a plan, the PBGC received any assets in the plan and made a claim against additional assets up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multiemployer defined-benefit plans, using a slightly higher annual premium, but guaranteeing only a portion of the participant's benefits.

During 1987, continued attention was focused on three important pension funding issues: (1) Termination of underfunded plans; (2) reversions of assets from termination of overfunded plans; and (3) investment performance of pension funds.

(1) Termination of Underfunded Plans

The past 5 years have brought increasing concern that the single-employer termination insurance progam, operated by the PBGC, is inadequately funded. By the end of fiscal year 1984, PBGC had liabilities of $1.5 billion and assets of only $1.1 billion—leaving a deficit of $462 million. Projections at that time indicated that without a premium increase the fund for single-employer plans would be exhausted by 1990. During 1985 the PBGC assumed $615 million in additional liabilities. By the end of fiscal year 1985, the PBGC reported liabilities of $2.7 billion and assets of only $1.4 billion—leaving a deficit of $1.3 billion.

A major cause of the PBGC's problem was the ease with which economically viable companies could terminate underfunded plans and dump their pension liabilities on the termination insurance program. Employers unable to make required contributions to the pension plan were requesting funding waivers from the IRS, permitting them to withhold their contributions, and thus increase their unfunded liabilities. As the underfunding grew, the company terminated the plan and transferred the liability to the PBGC. The PBGC was helpless to prevent the termination and was also limited in the amount of assets that it could collect from the company to help pay for underfunding to 30 percent of the company's net worth. PBGC was unable to collect much from the financially troubled companies since they were likely to have little or no net worth.

Terminations of underfunded pension plans have also reduced the benefits paid to participants and beneficiaries. Even though vested benefits are generally insured by the PBGC, the termination insurance program does not protect all benefits vested in underfunded plans. Employees are often in a difficult position when an employer terminates an underfunded plan. On the one hand, termination will result in a loss of benefits. On the other hand, the inability of the company to restructure its debt may force the company to go out of business and the workers to lose their jobs.

While during the past few years, the PBGC has assumed responsibility for several large claims, none was as large as that of the LTV Corporation, which filed for chapter 11 bankruptcy in 1986. LTV's three terminated steel pension plans doubled PBGC's deficit from $2 billion to $4 billion and illustrated a fundamental weakness of the termination insurance program. Under the law, companies such as LTV could eventually become profitable, in part because they had succeeded in dumping pension liabilities on the PBGC. The result was that participants in the pension plans of such companies (through some loss in benefits) and the companies' competitors (through higher premiums to the PBGC) were subsidizing their future profitability.

During 1986, several important events took place with regard to pension underfunding. First, the premium paid to the PBGC by employers was increased form $2.60 to $8.50 per participant. In addition the circumstances under which employers can terminate underfunded pension plans and dump them into the PBGC's lap were tightened up considerably. A distinction is now made between "standard" terminations, where the employer is not in financial trouble and "distress" teminations, where the employer is unlikely to have adequate assets to meet plan obligations. In a standard termination, employers will have to pay all benefit commitments under the plan, including benefits in excess of the amounts guaranteed by the PBGC that were vested to termination of the plan. A distress termination—where a company has filed for bankruptcy, or will clearly go out of business unless the plan was terminated, or where the cost of the pension has become unreasonably burdensome—involves increased employer liability to both the PBGC and plan participants.

While significant accomplishments were made in 1986, however, the new changes did not solve the PBGC's financing problems. The insurance agency's troubles grew substantialy worse with the termination of the pension plans of the bankrupt LTV Corporation at the end of 1986 and beginning of 1987. As a remedy, a provision in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) calls for an additional PBGC premium increase as of 1989. Beginning in 1989, firms will be required to pay a premium ranging from $16 to $50 per employee. This "variable-rate premium" will penalize those companies with large unfunded liabilities. While the companies sponsoring the 83 percent of all pension plans which are adequately funded will only be required to pay $16 per employee, companies sponsoring the remaining 17 percent will be forced to pay a variable premium, according to their level of underfunding. The new law will require companies to pay an additional $6 per employee for each $1,000 of underfunding. According to the PBGC, roughly 4 percent of all plans will pay the maximum rate of $50 per employee. Companies will also be required to make quarterly payments to the PBGC, rather than annual payments as has been the case. Due to the difficult conditions presently existing in the steel industry, the new provisions gave steel companies a 5-year transition period.

The new variable-rate premium resulted from lengthy debate. The administration had proposed a variable-rate premium ranging from $8.50 to $100 per employee. Unions bitterly opposed the administration proposal, stating that it would deepen the crises of companies which are already financially troubled. Therefore, the unions favored a Democratic alternative calling for a $20 flat-rate premium. However, this idea was unacceptable to the business community. In the end, the above-mentioned compromise was enacted into law.

The premium increase aside, however, PBGC's financial picture could be helped drastically if the agency is successful in returning to LTV the responsiblity for administering its three pension plans. While the PBGC took the plans over in January 1987, in September, after LTV had reported substantial operating profits, the PBGC won a court decision to return the plans to the company. LTV subsequently filed suit to return the plans to the PBGC. While LTV maintains that its business situation has not improved enough to warrant the return of the plans, others argue that if LTV is allowed to reduce its liabilities through bankruptcy, other firms will feel free to do so. The LTV case is still pending and could conceivably last for years. Should the PBGC be successful, however, its $4 billion deficit would be cut in half.

(2) Reversions of Assets from Termination of Overfunded Plans

Concern in the Congress continued in 1987 over the termination of well-funded defined-benefit pension plans to enable plan sponsors to recapture the surplus assets. Under ERISA, sponsors of plans with assets that exceeds ERISA funding standards can recover these surplus assets over time by reducing their contributions to the plan. Withdrawals of assets are not permitted as long as the plan remains in operation. Employers can recover assets, however, when a plan is terminated.

In recent years, a substantial increase in plan surpluses due to bond and stock market gains and an increasing awareness of the potential for recovering plan assets, has caused employers to consider terminating well-funded defined-benefit plans for a variety of business reasons unrelated to the purposes of the retirement plan. The major reasons for termination have included: Financing or fending off corporate takeovers, improving cash flow or redirecting the company's assets, and modifying the company's retirement income plans.

Originally, employers were loathe to terminate pension plans simply to recover assets because of a concern that plan participants might lose benefits and the PBGC would prevent them from offering a similar successor plan. The issuance of Implementation Guidelines for Asset Reversions by the PBGC, the Treasury Department, and Department of Labor in May 1984 helped clarify that an employer could terminate one plan and establish a similar successor plan as long as all plan participants were vested and benefits were fully covered under annuity contracts. This clarification has given rise to a host of new plan terminations that have left participants covered under identical or similar, and often less secure successor plans.

The number and size of reversions from plan terminations has been increasing steadily in recent years. Since 1980, employers have terminated more than 1,300 pension plans and recovered nearly $16 billion in assets. Much of this money has gone for mergers, takeovers, and other purposes which are often contrary to the interests of the workers covered by the raided pension plans. The largest reversion in history occurred in 1985 when United Airlines recovered over $962 million through the termination of five pension plans. The acceleration of plan reversions is likely to continue until Congress takes action.

Employees whose company terminates a pension plan to recover its assets usually remain covered under the old plan or a successor plan. The two common methods for leaving participants covered under a defined-benefit plan—"spinoff" termination and "re-establishment" termination—essentially leave participants benefits unchanged. Under a spinoff, the old pension plan is split in two—one-half covering retirees and the other half active employees. While active employees remain in the old pension plan, the surplus assets are placed in the retiree plan, which is terminated, and annuities are purchased for the retirees. Under a re-establishment, the old pension plan is terminated and a new similar plan is created, with past service credits normally provided in the new plan for all active employees. By using either approach, employers are doing in two steps what they would not be allowed to do in one.

Many have raised serious concerns about the equitability of employer recovery of excess pension plan assets. Critics argue that retirees can be harmed in a spinoff termination because they lose the potential for future cost-of-living increases in their benefits. They also contend that reversions draw needed assets from the plans and may increase the risk for the PBGC because newly created plans are not required under ERISA to maintain a funding level as high as plans that have been in existence for some time. This risk became apparent during the October 19, 1987, stock market crash, when pension plans lost billions of dollars in assets.

Plan sponsors counter that the real problem is that to recover excess assets, employers are currently forced to terminate pension plans. They believe that since the company, in a defined-benefit plan, promises specified benefits to employees, only the benefits earned to date—not the assets in the plan—belong to participants. The sponsors argue that employers are responsible for adequately funding these benefits and should be permitted to recover funds not needed to pay benefits. Under current law, employers can reduce their contributions to recover surpluses over time. Employers argue they should not have to wait.

Some observers have suggested that the recovery of these additional assets is weakening the funding of pension plans and undermining the purposes of the ERISA funding standards. They have proposed that sponsors should be permitted to recover the assets not needed on a continuing basis but be prevented from recovering additional assets if they are going to continue coverage for their employees under a successor plan.

Throughout 1987, the reversion debate centered around whether or not employees should share the benefits of assets recovery. During consideration of the Omnibus Budget Reconciliation Act of 1987 (OBRA), reversion proposals of the House and Senate Labor Committees, the House Committee on Ways and Means, and the Senate Finance Committee were debated.

The proposals of the Senate Finance Committee and the House Ways and Means Committee essentially retained current law by disallowing asset withdrawals from ongoing pension plans. The House version, however, called for an asset cushion in the event of a termination withdrawal and a 20 percent excise tax on plan reversions. A 10 percent excise tax was passed as part of the Tax Reform Act of 1986.

Critics of the tax committee proposals argue that preventing firms from withdrawing excess assets acts as an incentive for plan terminations, thus jeopardizing retiree benefit security. They add that such prohibitions could encourage plan underfunding. Proponents, on the other hand, argue that excess assets should be used to fund plan improvements such as cost-of-living adjustments. While they believe that these strict rules are the only way to effectively guarantee benefit security, critics believe that benefit security necessitates discouraging plan terminations.

The submissions of the House and Senate Labor Committee would have allowed asset withdrawals, but would have required that employers share the spoils with their employees. Withdrawals of excess funds would be permitted if a cushion of 125 percent of liabilities was left in each plan maintained by the company. Were a plan to be terminated, employers would be required to share a portion of its assets with their employees.

The differences between the Labor and tax committee proposals prompted several Members of Congress to speak out. In a letter to members of the Senate Special Committee on Aging, Senators Melcher and Heinz expressed their concern that asset reversions represent "a serious threat to the retirement income of American workers." They argued that retaining the old administration guidelines by enacting the tax committee proposals prohibiting withdrawals would encourage plan terminations, whereas the proposal by the Senate Committee on Labor and Human Resources would not. Those in agreement argued that requiring companies to share assets from terminated plans with plan participants would serve as a deterrent to plan termination. They added that, because pension funds represent deferred wages, employees are entitled to an equitable share of the assets.

Others went even further. Pension rights advocates proposed that employers only be allowed to withdraw excess assets if they also restored the value of retirees' pensions. Such an undertaking would entail increasing the monthly benefits for retirees by 100 percent of the increase in the consumer price index since the date of their retirement. Unlike Federal retirement programs, private pension plans are not required to provide increases in the cost-of-living. Advocates argued that only when both pension benefits and their value are protected can employers justifiably recover excess assets.

In the end, however, while OBRA provided for a PBGC premium increase, it included no provisions on the recovery of excess pension assets. Companies may still terminate plans without regard to their employees' future benefit security, and without sharing the profits. Simply because reversion provisions were not included in OBRA, however, does not mean that the issue has been resolved in the eyes of Congress. During 1988, the reversion issue will likely continue receiving attention. Similar arguements will be made once again, with the strong possibility that this time, changes will be made.

(3) Investment Performance of Pension Funds

Over the last few decades, pension funds have become one of the largest single-purpose pools of capital in the economy. As of September 30, 1986, the Employee Benefit Research Institute (EBRI) estimated that the assets in private trusteed pension funds had grown to $1.015 trillion—an amount representing approximately 54 percent of all private, State, and local pension assets. According to findings published by the Department of Labor after a series of hearings in 1985, pensions have been becoming a dominant factor in stock trading markets. The Labor Department viewed the recent increase in pension fund assets as concomitant with an increase in daily trading on the Stock Exchange, annual turnover rates of up to 70 perecent of pension funds a year, and a growing trend toward corporate takeovers. However, late in 1987, the recent increase in assets came to a grinding halt.

On October 19, 1987, the Dow Jones Industrial Average lost a historic 508 points. With that drop, $210 billion in pension assets vanished—10 percent of the country's pension portfolios. This prompted concerns in many circles that, because some plans are heavily invested in the stock market, the pension benefits of many retirees could be in grave danger. Despite the catastrophe many believed the collapse could portend, however, the benefits of most retirees remain relatively secure. The major exception involves defined-contribution pension plans.

According to the EBRI, private defined-contribution plans lost about $60 billion in direct stock holdings—13.3 percent of total assets—on Black Monday. Prior to the crash, defined-contribution plans had approximately $450 billion in total assets, at least $200 billion of which was in equities. At the same time, defined-benefit plans lost 12.4 percent—$88 billion of $707 billion—of total assets.

The diminution of benefit security for those covered by defined-contribution plans as opposed to defined-benefit plans derives from who bears the investment risk. Defined-benefit plans promise a certain benefit level to employees, while defined-contribution plans do not. Under a defined-contribution plan, an employer simply promises to contribute a certain annual amount to an employee account.

Since defined-contribution plans, which often are heavily invested in stock, have lost such a large portion of their assets, many covered employees have experienced at least a temporary loss of retirement security.

A recent a report by the Congress Research Service (CRS) evaluated the stock market downturn's effect on pension plans. CRS found:

> The stock market downturn did not have a direct impact on the pension benefits of participants in defined-benefit plans. However, those in defined-contribution plans may see the value of their accounts drop sharply.
>
> Asset diversification partially insulated pension plans from the market downturn. Less then half of pension assets are in the stock market.
>
> The value of private pension equity holdings on December 2, 1987, declined almost 31 percent from the market top of August 25, 1987. However, pensions funds experienced an overall decline of 15 percent.
>
> Just as many pension plans were adversely affected by the market plunge, they benefited by market gains over the past 5 years.
>
> The assets in single-employer, defined-benefit plans dropped an estimated $40 billion on Black Monday, but were still $177 billion in excess of plan liabilities.
>
> The PBGC lost an estimated $146 million in the value of its equity holdings during Oct. 1987.

The crash was the culmination of the longest bull market in the country's history. It demonstrated that while pension plans could benefit from stock market jumps, they were equally open to the adverse effects of collapses.

Not only were the assets of many defined-benefit and defined-contribution pension plans diminished by the stock market downfall, but defined-benefit plan liabilities were moderately increased due to a simultaneous reduction in interest rates. Reacting to the market dive, the Federal Reserve injected liquidity into the system by lowering interest rates. The interest rate decline lowered the assumed rate of return for employee pension plans, thus increasing the cost, at least on paper, of meeting future plan liabilities. This occurred because the present value of future liabilities is computed using a combination of assumed interest rates, salaries, growth, and inflation. All else remaining equal, should interest rates decline, liability estimates can dramatically increase. A change of only 1 percent in interest rate assumptions can alter plan costs by 25 percent. While plan liabilities may have been appreciably altered between October 16, 1987, and October 19, 1987, however, longer range estimates show something different. According to a preliminary Department of Labor estimate, defined-benefit plan liabilities only rose from $658 billion to $659 billion between December 31, 1986, and October 19, 1987. This resulted, in part, from an increase in interest rate assumptions between December 1986 and the time of the crash. That increase served to partially offset the interest rate reduction that occurred as a result of the crash. Therefore, while assets were down by almost 19 percent, plan liabilities at the end of Black Monday stood approximately where they had been in late 1986.

While most overfunded plans do not appear to have been appreciably jeoparidized by Black Monday, the story may be quite different for some underfunded plans. For example, some estimates show that the pension plans at LTV Corp., which were already underfunded by about $1.3 billion prior to the crash, may now have an additional shortfall of more than $100 million. Many companies with large unfunded liabilities other than LTV were also adversely affected by the crash. The result could be the collapse of certain pension plans which were already on the brink of disaster.

A rise in pension terminations resulting from the stock market collapse could appreciably increase the funding burden of the PBGC, which also lost assets on Black Monday. A November estimate by Pensions & Investment Age showed that the PBGC lost about $146 million during the first 26 days of October, assuming its managers performed on par with the index. However, just as the PBGC, like other corporations, experienced losses during October, it had benefited from the previous bull market.

While the stock market crash may adversely affect some retirees' pensions, among its most important outcomes may be its effect on the pension reversion issue. The crash highlighted the fact that sharp falls in the market can drastically decrease the level of pension plan overfunding. For many, Black Monday raised the question of whether pension assets should be drawn down at all, due to the potential added risk to retiree benefit security. It also flared concerns about the cushion that should be left in a plan from which assets are recovered. After Black Monday, many expressed concern that if asset reversions are allowed, a cushion of 125 percent of plan liabilities may be too low. Whatever the case, this issue promises to receive continued attention during 1988 and that attention will most likely be colored by thoughts of October 19.

(D) PENSION ACCRUAL

A provision in the Omnibus Budget Reconciliation Act of 1986 required that the IRS, the EEOC, and the Department of Labor issue regulations requiring employers to continue accruing pension benefits for employees working beyond normal retirement age by early 1988.

The EEOC was the first agency to issue proposed regulations. Due to concerns about their adequacy, as well as a lack of coordination with the other agencies, however, Senators Melcher, Metzenbaum, and several other Members of Congress informed EEOC of their concerns. (See chapter 5, pension accrual section.)

(E) PENSION COVERAGE BY SMALL EMPLOYERS

A bill introduced by Senator David Pryor to encourage small businesses to provide their employees with pension coverage received some attention during 1987. The bill, The Small Business and Retirement Extension Act (S. 1426), would provide a new tax credit for administrative costs incurred in connection with maintaining a pension plan, as well as repeal top-heavy rules which currently assure lower paid employees of receiving meaningful pension benefits under plans in which 60 percent of the pension benefits go to key employees.

On October 23, 1987, the Senate Subcommittee on Private Retirement Plans and Oversight of the Internal Revenue Service held a hearing on the bill. The subcommittee heard testimony from a variety of organizations, most of which were representatives of small business. While most witnesses supported repealing the top-heavy rules, critics complained that bill supporters could not substantiate that the rules now place an excessively heavy burden on small businesses. While proponents of the bill maintained that the pension reforms in the Tax Reform Act of 1986 regarding integration and vesting make the top-heavy rules unnecessary, critics argued that there was little evidence to suggest that their repeal would cause an increase in new plans.

Critics of the bill cited studies by GAO and CRS which showed that lower paid workers would receive higher pension benefits under the top-heavy rules than if they were replaced with certain provisions of the Tax Reform Act. They argued that women would be hit hardest by such a change.

Proponents, on the other hand, argued that the bill would promote the interests of small businesses, which employ nearly half of the American work force. They claimed that S. 1426 would enable small employers, most of which do not currently provide pensions, to more easily and cost-effectively provide and administer such plans.

3. PROGNOSIS

Most of the pension issues that have commanded attention in recent years were resolved in 1986. The sheer volume of pension reform legislation enacted during that year has dampened the enthusiasm of the Congress in considering most pension legislation for the next few years.

Pension funding issues, however, remain the major exception to this rule. While the financial picture of the Pension Benefit Guaranty Corporation should be aided by the premium increase scheduled for 1989, other issues such as reversions of excess pension assets promise to receive a great deal of attention in the near future. Among the cogent issues which must be addressed is whether employees are entitled to receive a portion of recovered assets. In addition, the question of whether or not an employer should be allowed to withdraw excess assets without terminating a pension plan is extremely important.

During 1988, Congress will likely continue exploring the prospects of expanded pension coverage among small employers. There exists growing recognition that the gap in pension coverage caused by the lack of small employer pension plans must be eased, and proposals such as the Small Business Retirement and Benefit Extension Act, promise to receive increasing attention.

The issue of pension portability alsc promises to receive increasing attention. Among the more prominent bills introduced during the 100th Congress have been H.R. 1961, H.R. 1962, and S. 944, the Pension Portability Act of 1987. The act would establish portable pension plans to be maintained by asset managers such as banks, mutual funds, and insurance companies. In addition, contributions to the plans would immediately be vested and would permit no integration with Social Security.

Pension benefit portability involves the ability to maintain an employee's benefits upon a change in employment. Proponents argue that the mobility of today's work force demands benefit portability. Alternatives to expand pension portability that will likely receive attention during 1988 include proposals to establish a Federal portability agency or a central clearinghouse, which would maintain accounts on behalf of workers, and proposals to expand the current retirement arrangements to require or facilitate rollovers of preretirement distributions to an employer plan or an IRA.

Attention in 1988 could also focus on the forthcoming rules regarding post-retirement age pension accrual. There are preliminary indications that the final pension regulations to be issued by the EEOC will not provide for retroactive coverage of pension recipients. No indications exist, however, as to the position that will be taken in the regulations to be issued by the Internal Revenue Service. Under OBRA 1986, the agencies were required to coordinate formulation of their regulations to avoid inconsistency. Since several Members of Congress submitted to the EEOC comments advocating retroactive coverage under the new regulations, they will be anxiously awaiting the determination of the IRS. Depending upon the final agency interpretations, further action in this area may occur in the not-so-distant future.

Finally, while most pension plans seemed to weather the storm caused by the October 19, 1987 stock market crash, should economic conditions deteriorate in the near future, some companies already in dire financial straits could fail. This could add to the financial burden already on the PBGC. However, only time will tell what future the economy holds for the country's pension system.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. Background

State and local government pension plans cover 11.4 million active and 3.1 million retired participants in more than 6,600 plans. As of December 2, 1987, State and local pension plans had assets of $479 billion. More than 80 percent of these plans have fewer than 100 active members each. About 95 percent of active membership are included in the largest 6 percent of plans. Nearly three-quarters of the State and local plans provide coverage under Social Security, but most do not integrate Social Security and pension benefits.

State and local pension plans intentionally were left outside the scope of Federal regulation under ERISA in 1974, even though there was concern at the time about large unfunded liabilities and the need for greater protection for participants. Although unions representing State and municipal employees, from the beginning, have supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups thus far have successfully counteracted these efforts, arguing that the extension of such standards would be an unwarranted—and unconstitutional—interference with the right of State and local governments to set the terms and conditions of employment for their workers.

(A) TAX REFORM ACT OF 1986

Public employee retirement plans were affected directly by several provisions of the Tax Reform Act of 1986. The act made two changes that apply specifically to public plans: The maximum employee elective contributions to voluntary savings plans (401(k), 403(b), and 457 plans) were substantially reduced, and the once-favorable tax treatment of distributions from contributory pension plans was eliminated.

(B) ELECTIVE DEFERRALS

The Tax Reform Act set lower limits for employee elective deferrals to savings vehicles, coordinated the limits for contributions to multiple plans, and prevented State and local governments from establishing new 401(k) plans. The maximum contribution permitted to an existing 401(k) plan was reduced from $30,000 to $7,000 a year and the nondiscrimination rule that limits the average contribution of highly compensated employees to a ratio of the average contribution of employees who do not earn as much was tightened. The maximum contribution to a 403(b) plan (tax-sheltered annuity for public school employees) was reduced to $9,500 a year and employer contributions for the first time were made subject to nondiscrimination rules. In addition, preretirement withdrawals were restricted unless due to hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remained at $7,500, but is coordinated with contributions to a 401(k) or 403(b) plans. In addition, 457 plans were required to commence distributions under uniform rules that apply to all pension plans. The lower limits were effective for deferrals made on or after January 1, 1987 while the other changes generally will be effective beginning January 1, 1989.

(C) TAXATION OF DISTRIBUTIONS

The tax treatment of distributions from public employee pension plans also was modified by the Tax Reform Act to develop consistent treatment for employees in contributory and noncontributory pension plans. Under prior law, public employees who had made after-tax contributions to their pension plans could receive their own contributions first (tax-free) after the annuity starting date if the entire contribution could be recovered within 3 years, and then pay taxes on the full amount of the annuity. Alternately, employees could receive annuities in which the portions of nontaxable contributions and taxable pension were fixed over time. The Tax Reform Act repealed the 3-year basis recovery rule that permitted tax-free portions of the retirement annuity to be paid first. Under the new law, retirees from public plans must receive annuities that are a combination of taxable and nontaxable amounts.

The tax treatment of preretirement distributions was changed for all retirement plans in an effort to discourage the use of retirement money for purposes other than retirement. A 10-percent penalty tax applies under the new law to any distribution before age 59½ other than distributions in the form of a life annuity: At early retirement at or after age 55; in the event of the death of the employee; or in the event of medical hardship. In addition, refunds of after-tax employee contributions, and payments from 457 plans are not subject to the 10-percent penalty tax. The new tax law also repealed the use of the advantageous 10-year forward-averaging tax treatment for lump-sum distributions received prior to age 59½, and provides for a one-time use of 5-year forward averaging after age 59½.

The act also made a number of changes that apply to tax-qualified pension plans, but do not apply directly to government plans. These include a reduction in the vesting period from 10 years to 5 years, modifications in the rules for integration of pension and Social Security benefits to require payment of at least half of a nonintegrated pension benefit, tighter pension coverage, and nondiscrimination rules to encourage broader participation in pension plans by lower paid employees.

2. ISSUES

(A) FEDERAL REGULATION

Issues surrounding Federal regulation of public pension plans have changed little in the past 10 years. A 1978 report to Congress by the Pension Task Force on Public Employee Retirement Systems concluded that State and local plans often were deficient in funding, disclosure, and benefit adequacy. The Task Force reported many deficiencies that still exist, including:

> Government retirement plans, particularly smaller plans, frequently were operated without regard for generally accepted financial and accounting procedures applicable to private plans and other financial enterprises.
>
> There was a general lack of consistent standards of conduct.
>
> Open opportunities existed for conflict-of-interest transactions, and frequent poor plan investment performance.
>
> Many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in inadequate funding that could place future beneficiaries at risk of losing benefits altogether.
>
> There was a lack of standardized and effective disclosure, creating a significant potential for abuse due to the lack of independent and external reviews of plan operations.
>
> Although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans—covering 20 percent of plan participants—did not meet ERISA's minimum vesting standard.

There remains considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. Recent studies suggest that the growth rate of public funds is outstripping the growth of private plans as public fund administrators move aggressively to fund unfunded liabilities. The sheer size of the investment funds suggest that a Federal standard might be prudent.

However, the need for improved standards has not obscured the latent constitutional question posed by Federal regulation. In *National League of Cities* v. *Usery,*[1] the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. The Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority*[2] overruling *National League of Cities* largely has resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pensions with respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be cleared by greater disclosure.

A definitive statement on financial disclosure standards for public plans was issued in 1986 by the Government Accounting Standards Board (GASB). Statement No. 5 on "Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers" established standards for disclosure of pension information by public employers and public employee retirement systems (PERS) in notes in financial statements and in required supplementary information. The disclosures are intended to provide information needed to assess the funding status of PERS, the progress made in accumulating sufficient assets to pay benefits, and the extent to which the employer is making actuarially determined contributions. In addition, the statement requires the computation and disclosure of a standardized measure of the pension benefit obligation. The statement further suggests that 10-year trends on assets, unfunded obligations, and revenues be presented as supplementary information.

(B) INVESTMENT PERFORMANCE

The most important occurrence to affect State and local pension funding during 1987 was the October 19 stock market crash, known as Black Monday. On Black Monday, the Nation's pension plans lost $210 billion in fund assets, much of this involving State and local plans. It is important to note, however, that while these plans lost a large portion of their assets as a result of the crash, they also had benefitted appreciably from the preceding bull market. As of December 2, 1987, State and local government plan assets totaled approximately $479 billion. While this was appreciably lower than the $562 billion in assets these plans had accumulated as of August 25, 1987, it was closer to the $503 billion in assets they owned on December 31, 1986. In fact, assets after Black Monday were higher than at the end of 1985, when State and local pension plan assets totaled about $432 billion.

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[1] 426 U.S. 833 (1979).

[2] 83 L. Ed. 2d 1016, 53 U.S.L.W. 4135 (1985).

State pension funds were seriously weakened by Black Monday. The Wisconsin State Employees Pension Fund for example, suffered a 20-percent loss in market value for the week of October 19, 1987, seeing its assets drop by well over $1 billion. The Michigan retirement fund also lost approximately $1 billion. While these losses were significant, they must be put in the proper perspective. For example, prior to the crash, the Michigan fund had assets of $16 billion. While one-sixteenth of those assets was lost on Black Monday, the Michigan State Treasurer's office has said that because of the previous bull market, Michigan's pension fund remains nearly $10 billion richer than it was in 1983. The story was similar in Wisconsin. According to the State of Wisconsin's Investment Board, Wisconsin's stock values on November 9, 1987, were about the same as they had been on January 1, 1987.

Like private plans, State and local plans were insulated partially from the market collapse by diversification in bonds, cash, and other nonequity investments. State and local plans were hardest hit by a decrease in the value of their equity holdings. The total value of State and local plans' equity holdings as of December 2, 1987, was $177 billion. This compares with pre-crash holdings of $255 billion on August 25, 1987, and $180 billion on December 31, 1986. The decline put State and local plan equity holdings in December 1987 within 2 percent of their value at the end of 1986.

The value of bonds held by State and local plans also experienced a slight decline. While their value had been $282 billion at the end of 1986, they had declined to $266 billion by August 25, 1987, with a further decline to $261 billion by December 2, 1987.

Over the long term, State and local pension plans should not suffer appreciably from the October 19, 1987, stock market plunge. For those plans, Black Monday served mainly as a reminder that the stock market moves in two directions. The true test will be economic conditions during and beyond 1988.

(C) SOCIAL INVESTMENT: SOUTH AFRICA DIVESTMENT

State and local pension plans are exceedingly vulnerable to local politics. At issue the last few years has been the continued investment of pension assets in companies that do business in South Africa. Since the stocks of many companies with investments in South Africa provide high yields, the divestment issue has been controversial in some areas. Action taken by State and local governments has ranged from full divestment of holdings in banks or companies that do business in South Africa to divestment of holdings only in companies that do not adhere strongly to the so-called "Sullivan principles" as well as "no new investment" policies.

On the local level, the movement for divestment of funds from corporations doing business in South Africa continued in 1987 due to continuing public concern about South Africa's apartheid policies. By August 1987, a total of 23 States and 75 cities had enacted some type of divestment policy. By contrast, as of October 1986, 19 States and 48 cities had passed either divestment or "no new investment" laws.

3. Prognosis

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments consistently have opposed Federal action, increased pressures to improve investment performance coupled with the call for responsible social investment may lessen some of the opposition of State and local plan administrators to some degree of Federal regulation. However, it is unlikely that Federal standards for public employee plans will get much serious congressional consideration in the near future.

C. FEDERAL CIVILIAN EMPLOYEE RETIREMENT

1. Background

From 1920 until January 1, 1987, the Civil Service Retirement System (CSRS) was the staff retirement plan for all Federal civilian employees. That was changed with the introduction of the new Federal Employees Retirement System (FERS), established by Public Law 99-335. CSRS covers all employees hired before January 1, 1984, who did not, by December 31, 1987, transfer to FERS. FERS also covers all Federal employees hired on or after January 1, 1984.

A key difference in the plans is that FERS benefits include Social Security payments which CSRS benefits do not.

Inclusion of Federal workers in the Social Security program was considered, but rejected, during enactment of the Social Security law in 1935. In subsequent years, it often was proposed, and always rejected, until enactment of the Social Security Amendments of 1983, which implemented a recommendation of the 1981 National Commission on Social Security Reform and mandated Social Security coverage for all Federal employees hired on or after January 1, 1984, or rehired on or after that date after separation from Federal service for more than 365 days.

Social Security coverage of Federal employees compelled the Congress to consider additional retirement benefits for such employees and afforded Congress an opportunity to examine various retirement options. The addition of Social Security coverage duplicated some CSRS benefits and would have increased combined employee tax contributions to more than 13 percent. Therefore, by Public Law 98-168 in 1983, Congress established an interim arrangement, pending enactment of a permanent new plan.

Congressional consideration and action extended over several months in 1985 and 1986, and enactment of the new permanent plan did not occur until June 6, 1986, the Federal Employees Retirement System Act of 1986 (Public Law 99-335).

That law established the new FERS and, in effect, designates CSRS as a closed system, which, unless earlier terminated, will cease to exist when the last employee hired before January 1, 1984, who remains in CSRS, retires and/or dies.

Presently, CSRS transfers to FERS, which are irrevocable, are not possible after December 31, 1987, except that workers returning to Federal service who previously worked at least 5 years under CSRS have a 6-month option period for transferring to FERS. At this point, it was not known how many CSRS members transferred to FERS during the transfer period; estimates range form 1.5 to 3 percent, far less than originally anticipated.

Two 1987 laws made necessary technical corrections in the law for both CSRS and FERS, Public Law 100-43 and Public Law 100-238, including: Making FERS early retirement available for law enforcement officers and firefighters after 3 years of primary duty instead of 10, and changing the FERS disability benefit to avoid a serious reduction at age 62.

2. The Federal Employees Retirement System Act of 1986 (Public Law 99-335)

(A) CIVIL SERVICE RETIREMENT SYSTEM

CSRS is the largest pension plan in the country, a pay-as-you-go system financed about one-fifth by employees' payroll taxes, one-fifth by the employing departments and agencies, and the balance (about $15 billion annually), from Federal general revenues. Federal employees make up about 3 percent of all U.S. workers.

The annual cost of the CSRS system increased from $2.5 billion in 1970 to $24 billion in 1986. The number of annuitants grew from 962,000 in fiscal year 1970 to more than 2 million in fiscal year 1987—a 119-percent increase. During the same period, total annuity payments increased 961 percent due mainly to large employment increases in World War II (resulting in a large increase in the number of retirement eligibles) and due also to full and automatic indexing of benefits during years of very high inflation. During the 1969-86 period, CSRS retirement benefits increased 197 percent, military retirement benefits 197 percent, and Social Security benefits 262 percent. During the same period the CPI for Urban Wage and Clerical Workers (CPI-W) increased 190 percent while Federal civilian pay increased only 133 percent.

CSRS participants' contribution continues to be 7 percent of total basic pay with no Social Security tax.

CSRS main benefits structure remains the same: After 5 years of service, vested benefits equal to a percentage of the highest 3 years of pay; unreduced benefits at age 55 with at least 30 years of service; unreduced benefits at age 60 with at least 20 years of service; unreduced benefits at age 62 with at least 5 years of service; credit of unused sick leave if employees continue to work until retirement; payment of benefits for those who leave Federal service before eligible for retirement cannot start before age 62, no matter how many years of service; employees have the right to withdraw their own contributions without interest and forfeit all CSRS benefits.

In fiscal year 1987, CSRS paid about $25 billion in benefits to about 1.5 million retirees and 534,000 survivors. Retiree benefits averaged about $1,100 per month, survivor benefits averaged about $500, and new 30-year benefit awards in fiscal year 1986 averaged $1,474.

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509) protects CSRS COLA's from cancellation by sequestration under the Gramm-Rudman-Hollings Act. But Congress through 1991 retains the right and power to reduce or cancel CSRS COLA's as part of budget action to meet budget targets and avoid sequestrations.

Under the administration's fiscal year 1988 budget proposal, CSRS COLA's would match the increase in the consumer price index (CPI) up to 2 percent. If the CPI increase exceeds 2 percent, the COLA would be the greater of 2 percent or the CPI increase minus 1 percent. However, Congress rejected that proposal and CSRS will receive the full 4.2 percent COLA in 1988.

Since 1987, a new Thrift Savings Plan (TSP) option has been available thorugh CSRS, under which up to 5 percent of an employee's pay can become tax-deferred. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) OBRA 1987 exempts TSP from anti-discrimination rules which apply to similar tax-deferred plans in the private sector. Therefore, all CSRS participants will be able to contribute the maximum to TSP and will not face possible reduction of the allowable contribution rate, no matter what their income level. The Government makes no matching contribution to the CSRS TSP.

CSRS is characterized as a good retirement plan for employees who know that they will remain in the employ of the Federal Government until they retire. However, it is described as not being well-suited to employees who may not spend their entire working careers in Federal service, since CSRS retirement benefits come from just one source. That source, because of inflation, gradually can lose its value for a person who leaves his or her job before retirement.

(B) THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM (FERS)

(1) Social Security Integrated With a Basic Defined Benefit Plan

The FERS plan actually is comprised of two benefits—FERS retirement benefits and an individual's Social Security benefit. The FERS benefit was designed to reduce the financial pressures that have increased in CSRS because of its generous early retirement benefits. FERS is less generous to early retirees in both the base benefit paid and COLA increases than it is to those who delay retirement. The FERS benefit plan is similar to private-sector plans in many respects, and allows workers to earn 1 percent of the average of their highest 3 consecutive years of wages for each year of service completed. Workers retiring at age 62 or later with at least 20 years of service will receive an additional 0.1 percent of pay for each year of service. Unlike CSRS, unused sick leave cannot be used for computation of retirement benefits.

In contrast to CSRS, the FERS benefit is reduced for retirement before age 62. Unreduced benefits from FERS will be payable at age 62 with 5 years of service, at age 60 with 20 years of service; and at the minimum retirement age with 30 years of service.

The minimum retirement age (MRA) is 55 for workers who reach that age by the year 2002, and increases by 2 months per year reaching age 56 in 2009. Beginning in 2021, the MRA again rises by

2 months per year until the full retirement age (57) is reached in 2027. Reduced benefits are payable to retiring employees past the MRA with 10 years of service, but insufficient service to be eligible for a full benefit. The reduction is 5 percent for each year under age 62. Workers who leave Federal service involuntarily at any age with at least 25 years of service, or after age 50 with at least 20 years of service, will be eligible for unreduced benefits.

Retirees with full benefits between the MRA and age 62 will be paid a supplement approximately equal to the amount of the estimated Social Security benefit based on Federal service payable to the retiree at age 62. This supplement also will be paid to involuntarily separated workers from age 55 to 62. Supplemental payments will be subject to an earnings test similar to that for Social Security beneficiaries.

Deferred benefits will be payable at age 62 to workers who cease Federal work before retirement, provided they have at least 5 years of civil service and have not withdrawn their contributions at separation. Deferred benefits also are payable without reduction to workers at the MRA with 30 years of service at separation or at age 60 with 20 years of service at separation. Reduced deferred benefits also are available at age 55 with a least 10 years of service. The reduction is 5 percent for each year under age 62.

Cost-of-living adjustments (COLA's) will be paid annually based on changes in prices measured by the Consumer Price Index (CPI) except that regular retirees under age 62 will not receive any increase. The COLA will match the CPI increase up to 2 percent. If the CPI increase exceeds 2 percent, the COLA will be the greater of 2 percent or the CPI increase minus 1 percent.

(2) Employee Contributions

Unlike CSRS, employees participating in FERS are required to contribute to Social Security. The tax rate for Social Security coverage was 5.7 percent of pay in 1986 and 1987, 6.06 percent beginning in 1988, and 6.2 percent beginning in 1990 up to the taxable wage ceiling ($45,000 in 1988). The wage ceiling is indexed to the annual growth of wages in the national economy. In FERS, employees contribute the difference between 7 percent of basic pay and the Social Security tax rate: 1.3 percent in 1987, 0.94 percent in 1988 and 1989, and 0.8 percent beginning in 1990.

At separation of service or retirement, employees will have the option of withdrawing their own contributions to FERS in an actuarially reduced lump-sum payment. For those not retiring, this choice becomes a relinquishment of the employer's contribution and they will be ineligible for deferred pension benefits at retirement. When the lump-sum is taken at retirement, it actuarially reduces the monthly retirement annuity the retiree (and any surviving spouse) will receive.

(3) Disability Benefits

Employees are eligible at any age for disability retirement after 18 months of creditable service if they are unable, because of disease or injury, to perform useful and efficient service in their current position or a vacant position at the same grade level in the same agency and commuting area. Employees applying for disability benefits under FERS may also apply for disability benefits under the Social Security system. Benefits will be based on the 3 highest years of pay and offset, to an extent, by Social Security benefits.

(4) Survivor Benefits

The survivor benefit plan features of FERS provides lump-sum payments to all surviving spouses of workers who die before retirement plus, in some cases, annuities to such survivors. Survivors of retired workers are eligible for an annuity if the couple elects the survivor annuity plan. The survivor annuity plan may be waived only if the spouse provides written, notarized consent.

Children's survivor benefits under FERS are payable to surviving children until age 18, or until 21 if they are full-time students. Disabled children incapable of self-support may continue to receive benefits for life if the disability began prior to age 18. All children's benefits are offset by any Social Security benefits payable.

(5) The Thrift Savings Plan (TSP)

FERS supplements the defined benefit plan with a contribution plan that resembles the popular 401(k) plans used by many private employers. Employees accumulate assets in TSP in the form of a savings account that either can be withdrawn in a lump-sum or converted to an annuity when the employee retires. One percent of pay will be automatically contributed to the TSP by the employing agency. Employees will be permitted to contribute up to 10 percent of their salaries to the TSP, and the employing agency will match the first 3 percent of pay contributed on a dollar-for-dollar basis, and will match the next 2 percent of pay contributed at the rate of 50 cents per dollar. Thus, the maximum matching contribution to TSP by the Federal agency will equal 4 percent of pay, and the automatic contribution of the agency will add another 1 percent of pay. Therefore, employees contributing 5 percent or more of pay will receive the maximum agency match.

An open season will be held every 6 months to permit employees to change levels of contributions and direction of investments. Optional investment opportunities will be phased in over a 10-year period, including special government securities, fixed-income securities, or a stock portfolio. Employees will be allowed to borrow from their accumulated TSP beginning in 1988 for the purchase of a primary residence, educational or medical expenses, or financial hardship.

All Federal employees covered by FERS on January 1, 1987, are eligible to participate in the FERS TSP. Employees hired after that date will generally have a 6–12 month waiting period.

At the end of fiscal year 1987, FERS covered 678,996 Federal civilian employees.

(6) Comparison of FERS Benefits and CSRS Benefits

The inclusion of FERS participants in the Social Security program allowed the plan's drafters to provide Federal workers with two design elements which should help to build a strong Government work force: Benefit portability and income replacement rates comparable to those found in the private sector.

Workers who do not expect to make a career of Federal service or who come in and out of Federal employment will be able to accrue Federal retirement benefits that can be accumulated with benefit from other employment. In addition, Social Security contributions will help workers build work quarters as they move in and out of the public sector.

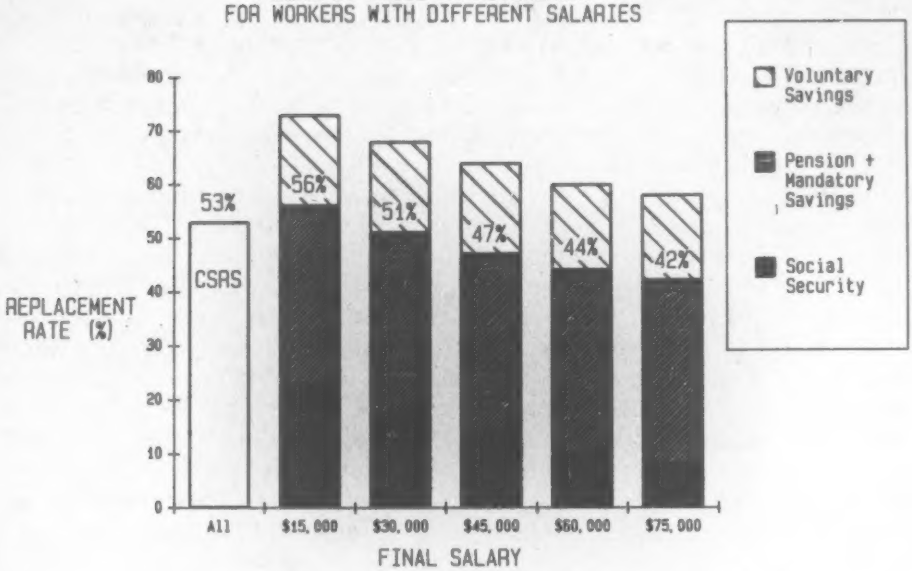
Benefits under CSRS provide replacement rates on the basis of years of service, not level of service, whereas Social Security is "titled" toward lower income workers by taking into account both eligible work quarters and salary levels. The chart below illustrates how the replacement rates for FERS will differ from CSRS, with the example of a 62-year-old worker retiring in the year 2030 after 30 years of Federal service. Adjusted to 1985 dollars, the gross replacement rate for this employee under CSRS would be 53 percent, regardless of the employee's salary level. Under FERS, however, the replacement rate will vary considerably with salary level. Assuming this employee made only voluntary contributions to the Thrift Savings Plan, the replacement rate would be 56 percent at a $15,000 final salary level, but would fall to 42 percent at a $75,000 level. These differences are attributable to the benefit structure of Social Security, since the pension portion of the retirement benefit is constant regardless of salary level.

It is estimated that the redesigned employee contribution feature of FERS will result in the cost of FERS being 22.9 percent of payroll (25 percent for CSRS).

It has been estimated that voluntary contributions under FERS will average 2.8 percent of salary.

CHART 1

BENEFIT VALUE AT RETIREMENT
FOR WORKERS WITH DIFFERENT SALARIES



NOTE: Assumes worker retiring in the year 2030 at age 62 with 30 years of service.

SOURCE: Congressional Research Service, Report No. 86-137 EPW

3. Issues

(A) LUMP-SUM WITHDRAWAL OF CONTRIBUTIONS

Public Law 99-335 contained a provision allowing those retiring under CSRS or FERS to withdraw at the time of retirement, their contributions to the system in exchange for a reduction in their annuity to reflect the withdrawn sum. This would mean a full actuarial pension reduction so that over the retiree's lifetime, the amount received together with the withdrawal would be the same amount which would have been received if the withdrawal had not been made.

This was a new option for Federal workers under CSRS. It is said that it was intended to partially offset the 1986 Tax Reform Act (Public Law 99-514) repeal of the 3-year pension-contribution-recovery tax rule. What was given with one hand may have been taken away with the other; before the 1986 tax law, that type of withdrawal would have been untaxed; the 1986 tax law made much, or most, of it taxable.

The administration's budget proposed repeal of that withdrawal provision as too costly, estimating that 85 percent of all retirees would opt for it, resulting in an estimated net cost of $3.7 billion over fiscal years 1988-90.

Much to the surprise of some, the OBRA 1987 changed the withdrawal rule for those voluntary retirees whose retirement annuities commence after January 3, 1988, and before October 1, 1989. The changes are: Beginning January 4, 1988, the lump-sum payable to nondisability retirees will be paid in two installments, 60 percent at retirement; 40 percent (with interest) 1 year after retirement. The change does not affect those who separated from service on or before January 2, 1988, nor those whose last day of pay was January 2, 1988, or earlier.

The new withdrawal provision applies to both CSRS and FERS.

(B) SOCIAL SECURITY PUBLIC PENSION OFFSET

Social Security benefits payable to spouses of retired, disabled, or deceased workers generally are reduced to take account of any public pension the spouse receives as a result of work in a government job not covered by Social Security. The amount of the reduction equals two-thirds of the government pension—$2 of the Social Security benefit for each $3 of the government pension. The offset does not apply to workers whose government job is covered by Social Security on the last day of the person's employment.

By transferring to FERS between July 1 and December 31, 1987, a worker covered by CSRS and not Social Security could become exempt from the public pension offset, immediately upon becoming covered by FERS. This aspect of the FERS law was before the 1987 Budget Reconciliation Conference Committee because of a provision in the House bill which would have made the exemption available only if and when a worker making the transfer to FERS has at least 5 years of Federal employment covered by Social Security after June 30, 1987. The Senate bill contained no comparable provision.

The conference agreement as implemented by OBRA 1987 makes that 5-year requirement applicable only to workers who elect to transfer from CSRS to FERS during any election period which may occur on or after January 1, 1988. The provision also applies to certain legislative branch employees who become covered under FERS on or after January 1, 1988.

There is some speculation that Congress may open a new period for CSRS transfers to FERS, but without the attractive public pension offset exemption provision.

(C) SOCIAL SECURITY WINDFALL BENEFIT REDUCTION

A provision of the Social Security Amendments Act of 1983 (Public Law 98–21) contains a formula for reduction of the Social Security benefits of workers who also have pensions from work not covered by Social Security (such as CSRS). The reduction formula applies only to those who have less than 30 years of Social Security coverage. Workers with 30 or more years of Social Security coverage are fully exempt from the reduction formula.

That new provision is being phased in over a 5-year period beginning with those first eligible for Social Security benefits and noncovered pensions in 1986. The resulting reduction in the Social Security benefit is limited to one-half of the amount of the noncovered pension.

The 1987 House budget reconciliation bill contained a provision that would have reduced the number of years required for exemption from the formula from 30 to 25 and would have scaled back the reduction formula on the basis of the number of years. The companion Senate budget reconciliation bill contained no comparable provision and the House provision was dropped in conference. This issue may resurface in the second session of the 100th Congress.

(D) MEDICARE PART B CATASTROPHIC ILLNESS COST PROTECTION ACT

(1) Supplemental Premium Formula

The Senate and House catastrophic health care bills (see chapter 8), in conference at the end of 1987, include separate formulas for determining the annual share of the cost of the additional protection to be paid by each Medicare enrollee as a Medicare Part B supplemental premium. The House formula is based on the enrollee's adjusted gross income; the Senate formula is based on the enrollee's income tax liability.

Because of the different tax statuses of Social Security and government pensions under the Tax Code, the original financing approach for each formula can result in supplemental premium inequities for government retirees and their survivors. Under the Tax Code, government pensions are almost fully taxable while no Social Security benefits are taxable, unless a retiree's income exceeds certain levels. It is estimated that only about 12 percent of Social Security beneficiaries have to pay tax on their benefits. In 1984, an estimated 2.6 million tax returns paid $2.7 billion in taxes on $7.9 billion of Social Security benefits; in 1985, 2.8 million returns paid $3.3 billion on $9.4 billion in benefits.

To address the financing inequity, an amendment was incorporated into the Senate bill to exclude $6,000 (the amount of the 1987 average Social Security benefit) of a single person's government pension ($9,000 for a couple) from taxable income for purposes of computing the supplemental premium liability. This provision is designed to protect government retirees from a higher supplemental premium than Social Security retirees with the same total income (Social Security included). The provision will benefit the estimated 1.32 million (1987) Federal annuitants and survivors 65 and older.

Because the House bill contained no similar provision, the issue will have to be resolved in conference.

(2) Medigap Insurance for Federal Retirees

During consideration of the catastrophic health care legislation, the Office of Personnel Management (OPM) informed Congress that under existing law a medigap-type health insurance policy cannot be offered to Federal retirees through the Federal Employees Health Benefits Plan (FEHB). OPM also reported that the policies authorized by FEHB provide coverage that largely duplicate the increased coverage offered by the catastrophic health care legislation.

Unless medigap-type policies were available through FEHB, Federal retirees would be confronted with higher than necessary premiums for duplicative coverage in addition to the excessive supplemental premiums mentioned above if the income tax inequity in the supplemental premium formula were not rectified. Even if the supplemental premium formula inequity was rectified, Federal retirees would be paying twice for the same coverage—the supplemental premium and the FEHB policy premium.

There was strong sentiment in the Senate for amending the FEHB law in the catastrophic bill to require OPM to make medigap-type policies (premium-priced as medigap policies) available through FEHB when the catastrophic health care bill became law. Some Senators were preparing amendments to that end, but were dissuaded by OPM and virtually all of the organizations representing Federal employees and Federal retirees as well as major insurance carriers offering health insurance through FEHB plans. Opponents of the initial amendments were concerned that this legislation would negatively affect FEHB policies. Further, health care analysts contended that it would not be possible to offer medigap policies through FEHB without first completely restructuring FEHB and the 430 insurance plans now available through it.

Instead, a provision was incorporated into the Senate bill reducing the FEHB preimums for Medicare eligibles. The provision also required OPM to report to Congress by April 1, 1989 on what changes would be necessary to enable FEHB to offer medigap-type policies.

As in the private sector, Federal retirees have come to consider employer-provided health insurance part of their retirement rights. It has been estimated that in 1983, one-fourth of the entire population of those older than 65 had some form of post-retirement health benefits (PRHB's)—at least 6.3 million. In 1984, at least 3.6 million early retirees and their spouses and 5.5 million regular retirees and their spouses were covered by a private- or public-employer health plan.

In 1984, the employer paid a portion of the cost for 80 percent of those 65 or over with PRHB's (84 percent of early retirees). Of that total, the employer paid full cost for 39 percent (42 percent for early retirees) and only 20 percent (16 percent for early retirees) had to pay the full cost themselves.

It was reported that the Federal Government pays 75 percent of the cost of each FEHB plan up to a certain level. Some plans exceed that cutoff level by so much that the worker or retiree often must pay as much as half the cost. In 1987 congressional hearings, witnesses said that Medicare-eligible retirees, through premiums for coverage they don't need (because medicare is the primary payer and their insurance secondary), are subsidizing the FEHB system. In late 1987 OPM contracted for a study of the problem; the report should be available in 1988.

(E) TAXATION OF LUMP-SUM PAYMENTS AT RETIREMENT

The Tax Reform Act of 1986 treated post-retirement lump-sum payments of employee contributions the same as full annuity payments. That is, the value of the lump-sum payment and the remaining annuity amount were combined and the proportionate shares of the employer's and employee's contributions were assessed. This rate then was applied to both the monthly annuity payments and the total lump-sum payment even though the lump-sum payment is paid in two installments under the 1987 act.

The new law places a penalty on the withdrawal of an employees' contributions in certain limited circumstances. The 10 percent penalty on early withdrawals from Individual Retirement Accounts (IRA's), except in cases of hardship, is extended to early withdrawals from qualified pension plans. This penalty will affect Federal workers under age 55 who retire under special early retirement provisions pertaining to job abolishment, or corporate reorganizations or reductions-in-force, and other Federal employees for whom normal retirement is age 50 with 20 years of service. Under the 1986 tax law, the withdrawal cannot be rolled over into an IRA or other qualified plan because it generally will not constitute 50 percent of the amount of the employee's lifetime annuity and, therefore, will not meet the IRS requirement for rollovers.

4. Prognosis

Congress probably will not make major changes, if any, in the structure of FERS in the foreseeable future. For CSRS participants, although Congress has demonstrated an intent to leave the system unchanged for those workers currently covered by it, some have expressed a fear that down the road, as FERS participants begin to outnumber CSRS participants, the voice of those dependent on CSRS will fade and beneficiaries will be forced to bear a disproportionate share of budget-cutting efforts. Already, CSRS retirees lost their 1986 COLA's as Congress and the President searched for ways to reduce the mounting Federal deficit. It remains to be seen whether this annual task can be accomplished without further reduction of retirement benefits for civil servants.

The sweeping 1986 tax overhaul contains many controversial provisions and has yet to be fully tested. Although Congress certainly will continue to amend the tax code, it is doubtful that the favorable tax treatment once accorded civil service retirees' lump-sum withdrawals of their own contributions soon will return.

It is reasonable to expect a new open period for CSRS transfers to FERS. Pension experts, surprised by the small numbers of transfers, claim that 40 percent of Federal workers would be better off under FERS. But some nontransfers reportedly have said: "If it ain't broke, don't fix it."

D. MILITARY RETIREMENT

1. Background

Until 1986, the military retirement system remained virtually the same as it had been since its inception following World War II, due to a vocal and effective lobby of participants and those who administer the program. In 1986, however, the "Military Retirement Reform Act of 1986" (Public Law 99-348) was enacted. The new law made several changes which will affect the benefits of those service-members first entering the military on or after August 1, 1986. Since a participant only becomes vested in the military retirement program after 20 years of service, the first retirees affected by the new law will be those with 20 years of service retiring on August 1, 2006.

In 1986, 1.5 million retirees and survivors received military retirement benefits. For fiscal year 1988, total Federal military retirement outlays have been estimated at $18.9 billion. Three types of benefits are provided under the system: Standard retirement benefits disability retirement benefits, and survivor benefits under the Survivor Benefit Program (SBP). With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants.

Servicemembers who retire from active duty receive monthly payments based on a percentage of their retired pay computation base. For persons who entered military service before September 8, 1980, the computation base is the final monthly base pay being received at the time of retirement. For those who entered service on or after September 8, 1980, the retired pay computation base is the average of the highest 3 years of base pay. Base pay comprises approximately 65–70 percent of total pay and allowances.

Retirement benefits are computed using a percentage of the retired pay computation base. The retirement benefit for someone entering military service prior to August 1, 1986, is determined by multiplying the years of service by a multiple of 2.5. Under this formula, the minimum amount of retired pay to which a retiree is entitled after a minimum of 20 years of service is 50 percent of base pay. A 25-year retiree receives 62.5 percent of base pay, with a 30-year retiree receiving the maximum—75 percent of base pay.

The Military Reform Act of 1986 (Public Law 99–348) changed the computation formula for military personnel who enter military service on or after August 1, 1986. For retirees under age 62, retired pay will be computed at the rate of 2 percent of the retired pay computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. Under the new formula, a 20-year retiree under age 62 will receive 40 percent of his or her basic pay, 57.5 percent after 25 years, and 75 percent after 30 years. Upon reaching 62, however, all retirees have their benefits recomputed using the old formula. The changed formula, therefore, favors the longer-serving military careerist, providing an incentive to remain on active duty longer before retiring. Since most military personnel retire after 20 years, the cut from 2.5 percent to 2 percent will cut program costs. These changes in the retired pay computation formula apply only to active duty nondisability retirees. Disability retirees and Reserve retirees are not affected.

Benefits are payable immediately upon retirement from military service, regardless of age and without taking into account other sources of income, including Social Security. By statute, all benefits are fully indexed for changes in the Consumer Price Index (CPI). However, the 1986 cost-of-living adjustment was canceled by the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings). Since then, amendments to Gramm-Rudman-Hollings have exempted military retirement COLA's from such sequesters. Under the Military Retirement Reform Act of 1986, however, cost-of-living adjustments (COLA's) will be held at 1 percentage point below (CPI) for military personnel beginning their service after August 1, 1986.

2. ISSUES

(A) COST

The military retirement system repeatedly has been criticized for providing lavish benefits, costing too much, and contributing to inefficient military personnel management. The Military Retirement Reform Act of 1986 was enacted in response to these opinions. The act's purpose was to contain the costs of the military retirement system and provide incentives for experienced military personnel to remain on active duty.

Approximately 1.5 million retired officers, enlisted personnel, and their beneficiaries received nearly $18.4 billion in annuity payments in 1986. At the current rate of growth, this expenditure will reach an estimated $45 billion annually by the end of the century. In 1986, military retirees received an average of $12,671 in annuities.

In particular, four identifiable features of the military retirement system greatly contribute to its cost:

(1) Full benefits begin immediately upon retirement; the average retiring enlisted member begins drawing benefits at age 42, the average officer at 46. Benefits continue until the death of the participant.

(2) Military retirement benefits are indexed for inflation.

(3) The system is basically noncontributory, although in order to provide survivor protection, the participant must make some contribution.

(4) Military retirement benefits are not integrated with Social Security benefits.

Supporters of the current military retirement scheme have identified several characteristics arguably unique to military life that they feel justify relatively more liberal benefits to military retirees than other Federal retirees:

(1) All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is ostensibly part compensation for this exigency.

(2) Military service places different demands on military personnel than civilian employment, including higher levels of stress and danger, and more frequent separation from family.

(3) The benefit structure has provided a significant incentive for older personnel to leave the service and maintain "youth and vigor" in the armed services. In this respect, it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Only a small minority of the studies conducted in the past decade have recommended contributions by individuals. As a result, no refunds of contributions are available to those leaving the military before the end of 20-years. And the full cost of the program appears as an agency expense in the budget, unlike the civilian retirement system where one-fifth of the cost is paid by employee contributions.

Finally, since the beginning of Social Security coverage for military personnel in 1945, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their middle forties retire after 20 years of service, it is not unusual to find them retiring from a second career with a pension from their private employment along with their military retirement and a full Social Security benefit. Lack of integration of military retirement and Social Security benefits generally adds to the perception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, a feature that retirees traditionally have considered central to the adequacy of retirement benefits. In recent years, full indexing of military and other Federal retirement benefits has become the object of most deficit-reduction measures. Most recently, the 1986 COLA was cancelled under the provisions of the Gramm-Rudman-Hollings Act. The act created two categories of programs that receive automatic COLA's: those for which COLA's would be suspended automatically in the event the Government failed to meet its deficit reduction targets and those that would be exempt from cuts. The military retirement plan (as well as the Civil Service Retirement System) was placed in the first category for the purposes of future sequestration. However, Gramm-Rudman-Hollings specifically forbids any reduction of military retirement benefits through sequestration.

In addition, the statute specifically suspended the 3.1 percent COLA scheduled for both military and civilian retirees in 1986. The cancellation of the military retirement COLA resulted in savings of $410 million in fiscal year 1987. For an average military retiree receiving a monthly benefit of $1,055.92, this resulted in a loss of $24.29 per month. Although one aspect of the Gramm-Rudman-Hollings Act was declared unconstitutional by the Supreme Court, Congress reaffirmed the cancellation of the 1986 COLA with a joint resolution in 1986 (Public Law 99-366). Military retirement benefits themselves, as well as COLA's, conceivably could be reduced through specific legislation adopted as part of congressional budgets designed to meet Gramm-Rudman-Hollings deficit reduction targets.

(B) RETIREMENT ADEQUACY

The temptation to use strict economic arguments in comparing military pensions to those found in the private sector is difficult to avoid, especially absent any immediate threat of war. The pivotal issue in evaluating the military retirement system, however, is not cost, but the system's ability to provide adequate retirement income to those men and women who serve in the Armed Forces. Several recent studies of the military retirement system have suggested that the 20-year service requirement is unfair to the majority of military personnel. Nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing the requisite 20 years of service. It has been suggested that this design is likely to prolong the careers of marginal military personnel beyond their usefulness, while simultaneously providing an incentive for highly skilled and experienced personnel to leave the armed services for second careers as soon as they complete 20 years of service, in order to capitalize on private sector employment opportunities and pensions. The result is a system that pays relatively high benefits to a disproportionately high number of officers when compared to the composition of the military as a whole.

Commenters periodically have called for shorter vesting schedules, comparable to those required for private plans under ERISA or for other Federal service jobs. Some military manpower experts have agrued that such a change would adversely impact the ability to maintain "youth and vigor" in the military work force. On the other hand, some military manpower analysts argue that the need for "youth and vigor" is overstated in view of new technologies that put a premium on technical skills rather than physical endurance.

(C) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan (SBP) was created in 1972 (Public Law 92–425). Under this plan, a military retiree can have a portion of his or her retired pay withheld to provide a survivor annuity to a spouse, a spouse and child, child only, a person with an "insurable interest," or a former spouse. As a result of the SBP, a military retiree can provide for an annuity of up to 55 percent of his or her total retired pay at the time of death to be paid to a surviving spouse. Upon reaching age 62, the SBP annuity automatically is reduced to 35 percent of military retired pay for all surviving spouses. This offset occurs regardless of whether the survivor is eligible for Social Security retirement or survivors benefits and regardless of any other sources of income available to the surviving spouse.

A retiree automatically is enrolled in the plan upon retirement at the maximum rate unless he or she chooses, in writing, not to participate or to do so at a lesser level of protection. If such a choice is made, the spouse must be notified. SBP annuities are adjusted for the cost-of-living on the same basis as military retired pay. No coverage reductions were made by the Military Reform Act. However, SBP benefits will be subject to the changes made in the formula for determining cost-of-living adjustments.

(1) Survivor Social Security Offset

Coverage of military service under Social Security entitles the surviving spouse of a military retiree to receive Social Security survivor benefits based on the deceased retiree's active duty military service. The Military Survivor Benefit Plan is integrated with Social Security. Since the original intent of the SBP was to provide a portion of the deceased military member's retired pay to the surviving spouse, it was considered appropriate that all sources of survivor benefits attributable to military service be included in the survivor benefit computation. As a result, Social Security survivor benefits payable because of military service were subtracted from the SBP so that the SBP and Social Security together would provide 55 percent of the retired pay to the surviving spouse.

(2) The Two-Tiered SBP

Some have questioned the equitability of the SBP. Military SBP benefits become payable immediately upon the death of the retiree, regardless of the age of the surviving spouse. Social Security widow(er)'s benefits are not paid until the survivor reaches age 60, while retirement benefits for a spouse with their own earnings record do not begin until age 62.

Under the "two-tier" system, if the surviving spouse is, for example, age 57 at the time of retiree's death, full SBP benefits are payable immediately, and will continue until the survivor reaches age 62. Surviving spouses without their own Social Security earnings record are able to draw full benefits for several years before having them reduced. However, survivors who will receive their own retirement benefits from Social Security must wait for them until age 62, the point at which their SBP annuity is reduced. For survivors who are not eligible for any Social Security benefits, SBP annities will be reduced even if they do not have additional retirement income when they reach age 62.

This difference in treatment of survivors may lead to future legislative activity. Although the "two-tier" SBP does provide certainly as to benefits payable, the fact that it may result in less than optimal targeting of limited Federal funds makes it ripe for further changes as Congress continues to wrestle with mounting deficits.

3. Legislative Activity in 1987

The only major legislation to receive action during 1987 was a bill to make technical corrections to Military Retirement Reform Act of 1986 (H.R. 2974) introduced by Representative Beverly Byron. The bill passed the House of Representatives and was amended and passed by the Senate in 1987. The House was expected to act on the Senate's modifications in 1988.

H.R. 2974 clarifies how COLA's are to be computed following a year in which no COLA is paid. In addition, the bill provides a formula for computing the increase in retirement pay due to an individual at age 62 who returns to active duty for any period of time after his or her initial retirement. The bill also revises the provisions relating to the prorating of initial CPI increase adjustments for new retirees.

4. Cost-Of-Living Adjustment

Military retirees, along with Social Security and other Federal retirees, received a 4.2 percent COLA effective January 1, 1988. The increase went into effect after a drawn-out debate regarding the possible elimination or reduction of 1988 Social Security and Federal retirement COLA's. In the end, the increase took effect without reduction or delay.

5. Prognosis for 1988

The long debate over the structure of the military retirement system was closed with the passage of the Military Retirement Reform Act of 1986, which set up a new system for new entrants into military service but left the existing system intact for those who had entered military service prior to August 1986. While it is doubtful that Congress will undertake major changes to either the old or new systems in the forseeable future, Congress in 1988 is likely to finalize the technical corrections legislation passed during 1987.

Two major issues involving the military retirement system remain. The first involves cost-of-living adjustments for military retirees and survivors. Some disagreement remains regarding whether military retirees should receive fully indexed COLA increases. The COLA issue will remain prominent as long as Congress and the administration continue to wrestle with the difficulties of deficit reduction. The second issue involves the benefit structure of the Survivor Benefit Plan. While interest continues about the current system's inequities, however, major changes are unlikely to occur in the immediate future.

E. RAILROAD RETIREMENT SYSTEM

1. Background

The Railroad Retirement System is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with the Social Security System. The system was authorized in 1935, prior to the creation of Social Security, and it remains the only federally administered pension program for a private industry. It covers hundreds of railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of vested so-called "dual" or "windfall" benefits, which are paid with Federal general revenue funds through a special account. At the end of fiscal year 1987, there were 939,600 retirement, disability, and survivor beneficiaries on monthly rolls consisting of: 330,700 employee age retirements averaging $773 monthly; 83,100 disability annuities averaging $708; 220,135 spouses averaging $327; 2,168 divorced spouses averaging $187; and 303,500 survivors averaging $470. Benefits totaling $6.5 billion were paid to those beneficiaries in fiscal year 1987.

The highest individual annuity awarded in 1987 was $1,578. The highest combined retiree and spouse annuities awarded in 1987 totalled $2,308.

2. Issues and Legislation

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

The broadest policy question associated with the Railroad Retirement System is simply: Does the country still need an independent, publicly administered railroad pension system? The general structure of the Railroad Retirement System results from its unique development.

In the final quarter of the 19th century, railroad companies were among the largest in America, and were marked by a high degree of organizational centralization and integration. The original Railroad Retirement System was created in 1934 to provide annuities to retirees based on rail earnings and length of service.

The Railroad Retirement Act of 1974 fundamentally reorganized the Railroad Retirement System and established the outline of its present organization. Most significantly, the legislation created a two-tier benefit structure in which Tier I was intended to serve as an equivalent to Social Security, and Tier II as a private pension. Tier I benefits are computed on credits earned in both rail and nonrail work, while Tier II is based solely on railroad employment. The total benefit continued traditional railroad annuities and, since 1974, eliminates duplicate Social Security coverage for nonrail and rail employment.

In every fiscal year budget since 1983, the Reagan administration has proposed dismantling the system and converting, to a private pension administered by a private corporation, all that portion of benefits in excess of Social Security, and turning over to Social Security the Social Security equivalent benefits of the system. This proposal was founded on the assumption that the Government should not administer an industry pension, and that given the intended equivalency of Tier I and Social Security, it is appropriate for Social Security to absorb the Social Security equivalent benefits, and create a privately administered pension to complement it, as is the case with all other private industries.

This proposal was rejected by Congress. Many felt that reorganization would lead to a cut in benefits for present and future retirees, and that, if exempted from ERISA standards as proposed by the administration, employees and retirees would have no guarantee that their full pensions would be provided. It was further argued that such a conversion would exacerbate Social Security's financing problems and create administrative difficulties for SSA, similar to the creation of SSI, and SSA's assumption of the Black Lung Program.

(B) RECENT FINANCING PROBLEMS

(1) The 1983 Retirement Fund Crisis

Rail employment determines the financial status of the system, because the system is financed by payroll tax revenues.

The late 1970's were not good years financially for the rail industry and by 1980, the retirement trust fund was faced with the prospect of financial difficulties and cash-flow problems. Declining rail traffic, and declining employment led to diminished payroll tax revenues.

Since the end of World War II, the worker/beneficiary ratio has been decreasing, as noted in the following table:

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

Year	Average employment	Beneficiaries	Ratio of workers to beneficiaries
1945	1,680	210	8.04
1950	1,421	461	3.08

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945—Continued

[In thousands]

Year	Average employment	Beneficiaries	Ratio of workers to beneficiaries
1955	1,239	704	1.76
1960	909	883	1.03
1965	753	930	0.81
1970	640	1,052	0.61
1975	548	1,094	0.50
1980	532	1,084	0.49
1981	503	999	0.50
1982	440	988	0.44
1983	395	981	0.40
1984	395	980	0.40
1985	372	954	0.39
1986	338	952	0.36

Source: Railroad Retirement Board, 1986, Annual Report, dated Oct. 23, 1987.

This 1980 long-term financing problem worsened because congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits, and appropriations shortfalls were paid from the Railroad Retirement trust fund.

To improve the system's financial condition, Congress included railroad retirement provisions in both the Omnibus Budget Reconciliation Act of 1981 (Public Law 97–35) and the Economic Recovery Tax Act of 1981 (Public Law 97–34). These amendments raised payroll taxes on employers and employees, modified benefits, created a separate account for windfall benefits, and provided the Railroad Retirement trust fund with authority to borrow from the General Treasury when near-term cash-flow difficulties arise.

Unfortunately, an economic recession devastated the railroad industry in the final quarter of 1982 and thwarted the intended benefits of the 1981 laws, bringing the Railroad Retirement System to the brink of insolvency and a treatened 40 percent cut in Tier II benefits in 1983.

Another financial drain on the fund was borrowing from the fund by the railroad unemployment insurance account. By 1983, those unpaid borrowings totaled $575 million.

In 1983, rail labor and management, following congressional instructions, collectively negotiated a comprehensive financing package and submitted it to Congress. This agreement was considered by Congress, revised and ultimately enacted. The final package was composed of payroll tax inceases, benefit reductions, and Federal contributions. Passage averted the threatened 40-percent reduction in Tier II benefits scheduled for 1983.

Key provisions of the Railroad Retirement Solvency Act of 1983 (Public Law 98–76) included:

(1) A COLA offset provision that required that the next 5 percent of Tier 1 (Social Security equivalent) COLA increases be subtracted, dollar for dollar, from Tier II (pension) benefits. This effectively eliminated the 3.5 percent COLA scheduled for 1984 and reduced the 1985 COLA from 3.5 percent to 2 percent. Justification for the COLA reduction came from the belief that the burden of producing solvency for the system should fall on

management and labor, through increased taxes, and retirees, through reduced benefits. That COLA offset provision applied only to beneficiaries on the rolls before January 1, 1984, and was estimated to reduce their Tier II benefits by a total of $920 million through the fiscal year 1988.

(2) The 60–30 early retirement unreduced benefit, which allowed employees with 30 years of service to retire at age 60 with full Tiers I and II benefits as if 65, was reduced to a 62–30 early retirement unreduced benefits rule and a 60–30 reduced Tier I benefit rule. The Tier II early retirement benefit was not reduced under the change. A 60–30 reduced Tier I benefit is recomputed at age 62.

(3) Three annual Tier II payroll tax inceases of 0.75 percent were levied on rail employees, and three annual payroll tax increases of 1 percent were levied on rail employers. This provision raised total payroll taxes from 13.75 percent to 19 percent; the employee rate from 2 to 4.25 percent and the employer rate from 11.75 to 14.75 percent.

(4) The wage base on which the employer-paid railroad unemployment insurance tax is levied was increased by 50 percent from the first $400 of monthly earnings to the first $600. A temporary employment tax was levied on employers on July 1, 1986, to repay the unemployment account debt to the retirement fund.

(5) Tier II benefits and vested dual benefits were subjected to Federal income taxation under the same guidelines as private pension earnings to the extent the pension income exceeds the employee's contributions. The revenues collected from this tax were to be transferred to the rail trust fund to finance benefit payments, through October 1, 1988. After that, the revenues were to remain with the Federal Treasury.

Tier I benefits were made subject to the Federal income tax, the same as Social Security benefits, by the Social Security Act Amendments of 1983 (Public Law 98–21).

Overall, the Railroad Retirement Solvency Act of 1983, through a combination of tax increases, benefit adjustments, and Federal assistance, was designed to guarantee the solvency of the Railroad Retirement System through the 1990's, even under pessimistic employment assumptions.

(2) The 1986–87 Fund Crisis

Following the 1983 law, there was optimism that, finally, the retirement fund was on a firm financial foundation, that rail industry employment would level off and stop the decline of the early 1980's, and that Congress would not soon be confronted again by retirement fund financial problems.

In its 1985 report, the Railroad Retirement Board characterized the long-term stability of the fund as "still questionable" because of its dependence on rail employment. "In the short term, however, defined as the next 10 to 20 years, even substantial declines in employment will not bring about cash-flow problems," [1] the report said. The report did not recommend any Tier II revenue tax increase or decrease, but did recommend a diversion to the unemployment insurance account of part of the revenue from the Tier II tax. Congress did not go along with that diversion.

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[1] U.S. Railroad Board, Sixteenth Actuarial Valuation, Sept. 1985, pp. 2-3.

In 1984 and 1985, the board supported a labor-management proposal to forgive interest on the unemployment account debt to the retirement fund, and told Congress the retirement fund would be overfunded by $2 billion if interest were required on the debt as provided by law. Congress did not forgive the interest.

In the board's 1986 report, the board's chief actuary, because of continuing decline in rail employment, recommended an added 1.5 percent Tier II tax, effective in 1987, and an additional 1.5 percent in 1988. In that report, the board chairman recommended only a 1 percent 1987 increase. The labor member of the board endorsed the chief actuary's recommendation, with both increases on the industry only. The management member of the board felt no increase was necessary.

The chief actuary's recommendation was based on projected cash-flow problems as early as 2003 under pessimistic assumptions, and in 2007 under optimistic assumptions.

In 1986, the administration recommended a 1.5 percent Tier II tax increase.

Because the Tier II tax had not been increased and rail employment continued to decline, the chief actuary's 1987 report recommended that a group be established to study the system and to consider different possible revenue sources for the system. The chief actuary also recommended that, in the meantime, the Tier II tax be increased 4.5 percent, effective January 1, 1988. He projected possible cash-flow problems as early as 2001, under pessimistic assumptions and the present financing structure.

In 1987, the administration recommended a 3 percent Tier II increase on January 1, 1988, and another 1.5 percent on January 1, 1989.

The Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) increased the employer Tier II tax from 14.75 to 16.1 percent and the employee Tier II tax from 4.25 to 4.9 percent, on wages up to $33,600, effective January 1, 1988. That total increase will raise an estimated additional $144 million in 1988, $182 million in 1989, and $183 million in 1990.

The 1987 law also increases revenue to the fund by an estimated $400 million by extending from October 1, 1988, to October 1, 1989, the cutoff date for transfer to the fund of revenue from the income taxation of Tier II and windfall benefits, and removing the $877 million cap on such transfers.

(3) The 1987 Commission on Railroad Retirement Reform

The seven-member commission, established by the 1987 act includes four-members appointed by the President (one recommended by rail labor, one recommended by rail management, one recommended by commuter railroads, and one representing the general public), one public member appointed by the president pro tempore of the Senate, one public member appointed by the Speaker of the

House, and one public member appointed by the Comptroller-General. The commission is to report to Congress by October 1, 1989.

(C) THE RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT DEBT

(1) The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272)

Prior to the 1983 Solvency Act, there were no requirements or provisions for repayment of the debt to the retirement fund. The debt was paid, in whole or in part, only if excess funds were available in the unemployment fund. As detailed above, the 1983 act instituted the first tax for repayment of that debt.

The 1985 act increased the rates of that tax to 4.3 percent, 4.7 percent, and 6 percent for 1986, 1987, and 1988, respectively. The act did not change the 2.9 percent rate or the 3.2 percent rate for 1989 and 1990, respectively, under the 1983 act.

Revenue from the repayment tax can be used only for repayment of the debt incurred prior to September 30, 1985, plus interest, and scheduled to expire on September 30, 1990. It is estimated that the unpaid balance on that date would be about $600 million. In September 1986, that debt, plus accrued interest was $866 million.

The 1985 Act also restored the authority to borrow from the retirement fund. That authority had expired in 1985 under the 1983 act. Additional borrowing triggers an additional 3.5 percent surtax on the industry under the act of 1985.

(2) Legislation in the 100th Congress, First Session

Congress remains concerned about the debt. In 1987, the House passed H.R. 2167, changing the repayment tax rate to 4 percent effective in 1989 and continuing that rate until the debt, with interest, is repaid in full, to occur in 1996.

H.R. 2167 would institute a new surcharge tax schedule—1.5 percent when the unemployment account's net assets fall below $100 million, 2.5 percent if less than $50 million, and 3.5 percent if below zero (net assets equal the balance in the account less loans incurred after September 30, 1985). There has been no additional borrowing since September 30, 1985.

H.R. 2167 was referred to the Senate Finance Committee, which did not take action on that bill in 1987.

In its fiscal year 1988 budget request, the administration, as it had in three previous budgets, proposed eliminating the present separate Federal unemployment insurance program for railroad employees and covering them under the Federal-State program, which covers the employees of all other private industries.

(D) TAXATION OF RAILROAD RETIREMENT BENEFITS

(1) Taxation of Tier I

(a) The 1983 Solvency Act

The negotiated recommendation of labor and management for taxation of the Tier I benefits the same as Social Security benefits was implemented by the Social Security Amendments of 1983 (Public Law 98-21).

The amount subject to tax is one-half of the excess of the total of adjusted gross income plus one-half of the total Tier I benefits for the year plus nontaxable interest income over the base of $25,000 for an individual ($32,000 joint) not to exceed one-half of total Tier I benefits for that year. (Adjusted gross income (AGI) does not include Tier I benefits.)

An example is an individual with $20,000 AGI, $6,000 Tier I benefits, and $3,000 tax-exempt interest income. The computation is $20,000 plus $3,000 (half of the $6,000 Tier I benefit) plus $3,000 ($26,000) minus $25,000 equals $1,000. The amount of Tier I subject to tax is one-half of $1,000, or $500, out of the $6,000 Tier I benefit.

For up to one-half of an individual's total Tier I income for the year to be subject to tax, the sum total of AGI plus one-half of the total Tier I plus tax exempt interest income must exceed $25,000 by an amount at least equal to the total of the Tier I income for that year.

A misconception, with some apparent general acceptance, is that no income tax actually is paid on Social Security or Tier I benefits. Statistics available from the Department of Treasury's Office of Tax Analysis for 1984 reveal that in 1984, almost $7.9 billion of Social Security benefits (5 percent of total benefits) and $113 million of Tier I benefits (2.8 percent of total Tier I benefits) were subject to income tax. Income tax paid was $2.7 billion and $35 million, respectively.[2]

It is estimated that for 1984, 2.6 million tax returns were filed with tax due on Social Security benefits; for 1985, 2.8 million

For 1985, $9.4 billion of Social Security benefits (5.6 percent of total benefits paid) and $125.9 million fo Tier I benefits (3 percent of benefits) were subject to income tax. Tax paid was $3.28 billion and $69 million, respectively. Estimates of income taxes for 1986 were $3.36 billion on Social Security benefits and $69 million on Tier I.[3]

It is estimated that about 12 percent of the beneficiaries pay Federal income tax on part of their Social Security benefits.

The 1983 Solvency Act established the Social Security Equivalent Benefit Account (SSEBA) under the Railroad Retirement System separate from the Railroad Retirement Account (RRA).

"From the SSEBA, retired rail workers receive the amount of Tier I benefits equivalent to the Social Security benefits they would have received had their service been covered under the Social Security system rather than the Railroad Retirement System. The tax liability of the Social Security-equivalent benefits is transferred to the SSEBA. The remainder of Tier I benefits is paid from the Railroad Retirement Account with the tax liability for this portion transferred to the Railroad Retirement Account. In 1985, the first full year in which taxes on the Tier I * * * benefits were divided between the two accounts, 84 percent were classified as SSEBA payments, with the remaining 16 percent classified as RRA benefits" [4] and, therefore, in excess of Social Security equivalent benefits.

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[2] Office of Tax Analysis, U.S. Department of the Treasury, Report on the Taxation of Social Security and Railroad Retirement Benefits in Calendar Year 1984, March 1987.

[3] Office of Tax Analysis, U.S. Department of the Treasury, Report on the Taxation of Social Security and Railroad Retirement Benefits in Calendar Year 1985, July 1987.

The total of Tier I benefits paid in 1985 was almost $4.2 billion. If the 16 percent of Tier I benefits in excess of Social Security equivalent benefits applies on average to all Tier I benefits paid that year, then the Tier I benefits paid in 1985 exceeded Social Security equivalent benefits for the year by over $500 million, all of which was paid out of the retirement account. The retirement account was not reimbursed by Social Security for any part of that amount under the financial interchange with Social Security.

(b) The Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) restricted the Social Security income tax formula to only the part of a Tier I benefit equivalent to the amount of the Social Security benefit. The act made the part of a Tier I benefit in excess of the Social Security equivalent amount (non-SSEBA) subject to tax the same as Tier II and all private pensions. This change became effective with the 1986 tax year.

The rationale for the change was that the rail employee Tier I tax is the same as the employee Social Security tax, and the retired rail employee should not have a greater income tax advantage than the Social Security beneficiary. The non-SSEBA is not paid out of the Social Security Trust Fund; rather, it is funded by employees' and employers' Tier II tax contributions, the same as Tier II benefits.

That change requires the board each year to make the necessary calculations to enable it to inform each annuitant of the amount of the Tier I benefit that is equivalent to Social Security and the amount, if any, that is in excess of the Social Security equivalent (non-SSEBA).

The board has made for OMB the following respective SSEBA and non-SSEBA projections for fiscal years 1987 through 1993:

Fiscal year	SSEBA (billions)	non-SSEBA (millions)
1987	$3.84	$521
1988	3.94	568
1989	4.11	571
1990	4.26	585
1991	4.41	591
1992	4.54	584
1993	4.61	587

The totals for 1986 are not yet available. The board estimates that the change in taxation will generate an additional $40 million in revenues each year.[5] Under the 1987 act, these additional revenues will be credited to the RRA account until October 1, 1989, the same as revenues from the taxation of Tier II benefits.

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[4] Ibid., p. 4.

[5] U.S. Railroad Retirement Board, 1986 Annual Report, Oct. 1987, p. 76.

(c) Legislation in the 100th Congress, First Session

Two bills were pending to repeal the provisions of the 1985 act restricting the amount of a Tier I benefit that can take advantage of the Social Secutiry income tax formula—S. 1155 and S. 1514, both authored by Senator John Heinz. S. 1155 would repeal the provisions prospectively; S. 1514, would repeal them retroactively.

The purpose of both bills is to amend the tax code so all Tier I benefits would be treated the same as Social Security for income tax purposes, whether all SSEBA, or part SSEBA and part non-SSEBA. Both bills were pending in the Senate Finance Committee.

(2) Taxation of Tier II Benefits

The labor-management negotiated recommendation for the taxation of Tier II benefits was implemented by the 1983 Solvency Act (Public Law 98-76). However, before final passage, the original bill was amended to deny Tier II annuitants "a fresh start." The tax became effective with the 1984 tax year; and the amendment charged all Tier II benefits received before 1984 against the recovery of the annuitant's tax contributions to the benefit, even though the benefits were tax-exempt under the tax law when they were received. That increased the income tax liability of Tier II annuitants who had retired before 1984.

The Tax Reform Act of 1986 (Public Law 99-514) eliminated the 3-year rule for the recovery of private pension contributions, including the employee Tier II tax. Under that rule, the pension benefits did not become taxable until the total contribution of the annuitant was recovered in benefits over an initial period not to exceed 3 years. Under the 1986 change, the non-SSEBA portion of Tier I benefits and all of Tier II benefits become taxable immediately upon receipt, but on a prorated basis as to the annuitant's contributions, taking into consideration the life expectancy of the annuitant. The same rule applies to all private pensions.

Under the 1983 Solvency Act vested dual benefits have been subject to income tax the same as Tier II benefits, effective with the 1984 tax year.

(E) BENEFIT QUALIFICATION RESTRICTIONS AND LIMITATIONS

(1) "Last Person Service" Rule

Perhaps the most troublesome qualification rule is the "last person service" rule, which requires a retiree to give up a job (full or part time) outside the rail industry to be eligible for an annuity. That rule has become more important in the last 8 or 9 years because, to reduce employment, so many railroad employers instituted combined early retirement and separation pay plans applicable to employees who would not be eligible for railroad retirement benefits for many years after leaving that employment. Many found satisfactory employment elsewhere, only to learn that they had to give up that emploment to collect those benefits upon reaching the prescribed age.

They could quit that job, and apply for the benefits, then go to work for another employer (not a railroad) and continue to receive the benefits, subject to the applicable earnings limitations. But they couldn't go back to work for the last employer immediately preceding the application for benefits. This restriction applies to spouses as well as retirees.

Over the years, there has been talk of eliminating that restriction. But, the board has opposed its elimination by asserting that, because it would increase benefit costs, its elimination should be accompanied by an offsetting increase in revenue to the fund.

H.R. 2167, passed by the House in 1987 would replace the "last-person service" rule with an earnings deduction formula, but leave in effect the prohibition against returning to work for a railroad. The reduction in the Tier I benefit would be the same as under the Social Security earnings limitations in present law. The reduction in the Tier II amount would be $1 for every $2 earned in last service employment, but the reduction could not exceed 50 percent of the monthly Tier II amount to which the annuitant would be entitled if not in last-person service. The change also would apply to supplemental annuities and spouse annuities.

Similar rules do not apply to Social Security benefits. Those benefits can be received without first giving up last-person service, subject only to the earnings limitations.

(2) Earnings Limitations

Tier I and vested dual benfits are subject to the same earnings limitations as Social Security: $1 deduction for each $2 earned over the limit. For 1988, the maximum earnings for the 65–69 age group are $8,400 (1987—$8,160), and $6,120 for those under 65 ($6,000—1987).

After the first year, the limits are based on total annual earnings, without regard to the number of months worked, and the amount earned in any particular month of the year.

During the first year of benefits, limitations are applied only in those months in which the amount earned exceeds one-twelfth of the annual limit.

Those earnings limitations do not apply to Tier II, nor, in all cases, to all of Tier I. The earnings deduction cannot reduce the Tier I amount to an amount less than the Tier I amount would be, if computed only on the annuitant's railroad service through December 31, 1974. Also, the non-SSEBA portion of a Tier I benefit is not subject to reduction for earnings over the limit.

Any railroad retiree contemplating going to work should ask the board's district office for a computation of the amount of the Tier I benefit that will not be subject to reduction for excess earnings.

Under present law, the deduction will change in 1990 to $1 for each $3 earned over the limit for the 65–69 age group. From age 70 on, there is no earnings limitation under present law.

Bills repealing or phasing-out the Social Security earnings limitations are pending in both the Senate and the House. There was no action on the bills in either the Senate or the House in 1987.

Opponents of earnings limitations claim they discourage the elderly from working and discriminate against those who need the additional income most—those with lower-than-average Social Security benefits. Those receiving the highest benefits can earn the same amount, without penalty. According to the Social Security

Administration, the 1984 cash income of the elderly was 38 percent Social Security and 16 percent job earnings. The median income of Social Security beneficiaries still working was $14,850 compared with a median income of $14,400 for those with a private pension to supplement Social Security, who are not working. Repeal supporters also maintain that the combination of income taxes and FICA on earnings and deductions for excess earnings can total what amounts to a tax rate of 50 percent or higher.

(F) COLA'S AND GRAMM-RUDMAN-HOLLINGS

A 1986 sequestration order, required by Gramm-Rudman-Hollings, reduced the vested "dual" benefits by almost 8 percent and continued the suspension of the Toier II COLA.

The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) restored the earlier cuts and prohibited sequenstration in and after fiscal year 1987 including Tier II COLA's, with the exception of supplemental annuities. The suspended Tier II COLA has not been restored.

Tier I COLA's, like Social Security COLA's, are exempt from sequestration.

A Presidential 1987 sequestration order required an 8.5 percent reduction in supplemental annuities, resulting in average reductions of $4 per month in about 200,000 supplemental annuities. Those annuities averaged $47 per month before the reduction.

That reduction was rescinded by the 1987 budget law (Public Law 100-203), but the reduction probably went into effect before the 1987 law was enacted. If so, the reduction will be restored by the board along with payment of any reductions actually made.

The supplemental annuity is the only annuity under the system that is not protected against sequenstration under Gramm-Rudman-Hollings.

In 1988, Tier I, like Social Security, became eligible for a 4.2 percent COLA; Tier II a 1.4 percent COLA (32.5 percent of the Tier I COLA).

During consideration of the 1987 budget reconciliation legislation, there was much discussion about reducing the Social Security COLA (including the Tier I SSEBA) as a contribution to reduction of the Federal deficit. Proposals to Congress ranged from elimination of the fiscal year 1988 COLA, a reduction to 2 percent, a uniform amount of COLA for all beneficiaries, no reduction, to increasing the portion of Social Security (Tier I SSEBA) benefits subject to the Federal income tax instead of reducing the COLA. Congress decided against eliminating or reducing the 1988 COLA.

In recent years, Congress has mulled limiting the Social Security COLA to the SSEBA portion of a Tier I benefit and reducing the COLA on the non-SSEBA portion of Tier I to 32.5 percent of the Social Security COLA, the same as Tier II. But it has not taken action in that direction and the whole Tier I still receives the full COLA.

3. PROGNOSIS

The 1987 Commission on Railroad Retirement Reform will report to Congress in 1989, pursuant to Public Law 100-203. Until Congress has had the opportunity to study and evaluate that report, no significant railroad retirement legislation is expected.

Just a couple of years ago, the feeling was relatively widespread that the 1983 Solvency Act and subsequent laws had stabilized the financial status of the system. The Reform Commission will have to make a thorough, in-depth study and analysis of the entire system and its benefits and financial structure to determine why the system is heading for financial difficulties again, and where and how the system can and must go from here.

Chapter 4

TAXES AND SAVINGS

OVERVIEW

In both design and application, the Federal tax code long has reflected a recognition of the special needs of older Americans. Helping to preserve a standard of living threatened by reduced income, the loss of earning power, and increases in nondiscretionary expenditures have been a primary objective of tax policy relating to the elderly.

Until 1984, Social Security and railroad retirement benefits, like veterans' pensions, were exempt from Federal taxation. That year, to help restore financial stability to Social Security, up to half of Social Security and railroad retirement Tier I benefits of higher income beneficiaries became taxable under a formula contained in the Social Security Act Amendments of 1983 (Public Law 98-21).

More recently, the Tax Reform Act of 1986 (Public Law 99-514), resulted in a number of other changes to tax laws of concern to older men and women. Under the act, longstanding tax advantages to the elderly were repealed or reduced, while increases in the personal exemption are to be phased-in, a higher increase in the standard deduction for the elderly provided and tax rates reduced (except for the lower income bracket rate, which was increased). The impact of these changes will not be fully known until early in the next decade.

A. TAXES

1. BACKGROUND

A number of longstanding provisions in the tax code are of special significance to older men and women. These include the exclusion of Social Security and railroad retirement Tier I benefits for low- and moderate-income beneficiaries, the elderly tax credit for the elderly, and the one-time exclusion of up to $125,000 in capital gains from the sale of a home for persons at least 55 years of age.

The Tax Reform Act of 1986 repealed or altered to less advantageous effect a number of tax provisions of importance to older persons. At the same time, other changes made by the act, such as the increase in the standard deduction provided for the elderly, may more than offset losses.

(A) TAXATION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

For more than four decades following the establishment of Social Security, benefits were exempt from Federal income tax. The Congress did not explicitly exclude those benefits from taxation. Rather, their tax-free status arose from a series of rulings in 1938 and 1941 from what was then called the Bureau of Internal Revenue. These rulings were based on the determination that if Congress had intended to make Social Security benefits taxable, it would have provided the legal authority to tax them when Social Security was created.

In 1983, the National Commission on Social Security Reform recommended that the Social Security benefits of higher income recipients be taxed, with the revenue put back into the Social Security trust funds. The propsoal was part of a larger set of recommendations entailing financial concessions by employees, employers, and retirees alike to rescue Social Security from insolvency.

The Congress acted on this recommendation with the passage of the Social Security Act Amendments of 1983. As a result, up to one-half of the benefits of Social Security and railroad retirement recipients with incomes over $25,000 (32,000 for joint filers) became subject to taxation. Since taxes already have been paid on the retired worker's share to the Social Security system, only the half regarded as the employer's contribution (and on which income taxes have not previously been paid) is taxable. In the case of railroad retirement recipients, only the Social Security-equivalent portion (Tier I) is affected. In 1987, approximately 12 percent of Social Security beneficiaries were subject to this tax.

The limited application of the tax on Social Security benefits reflects the congressional concern that, at least initially, lower- and moderate-income tax payers not be subject to this tax. Because the tax thresholds are not indexed, however, with time, beneficiaries of more modest means will also be impacted.

The tax treatment of Social Security benefits is noteworthy for another reason. Under the 1983 formula, Social Security income became the only initially tax-exempt income which can be pulled (up to 50 percent) into taxable income and tax-exempt interest income.

Revenues from the taxation of Social Security benefits have continued to increase. In 1984, approximately $3 billion in taxes were paid into the Social Security trust fund. In 1985, that figure rose to $3.4 billion, and in 1986, to $3.7 billion.

In 1987, as a result of the lower tax rates provided under the Tax Reform Act of 1986, tax revenues from Social Security are expected to slip to $3.5 billion. But they are expected to resume their climb each year thereafter.

(B) ELDERLY TAX CREDIT

Officially named the Tax Credit for the Elderly and the Permanently and Totally Disabled, the elderly tax credit was enacted in 1954 with the codification of the Internal Revenue Code. Under this provision, qualifying retirees receive a tax credit equal to 15 percent of the first $5,000 (for single filers) and $7,500 (for joint filers).

Congress established the credit to correct inequities in the taxation of different types of retirement income. Prior to 1954, retirement income generally was taxable, while Social Security and railroad retirement (Tier I) benefits were tax-free. To provide roughly similar treatment of these different types of retirement income, the new provision allowed retirees, 65 and older, a tax credit equal to 15 percent of the total of all retirement income.

In the Social Security Act Amendments of 1983, the Congress limited the credit to those 65 and older, or disabled. The act also increased the inital amounts which qualify for the credit.

(C) ONE-TIME EXCLUSION OF CAPITAL GAINS ON THE SALE OF A HOME

The one-time home sale capital gains exclusion originated in the Internal Revenue Act of 1964. It was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation. In addition, proponents asserted that the Government should not tax away assets people had accumulated for retirement through home-ownership, nor discourage elderly persons from selling their homes to reduce expenses or to move to smaller quarters.

Originally, capital gains of $20,000 of the adjusted sales price of the home of persons 65 and older were excluded. Over the years, Congress raised the maximum excludable gain to $125,000 to reflect increases in average market prices for housing and lowered to 55 the age at which the exclusion can be taken.

(D) TAX REFORM ACT OF 1986

The Tax Reform Act of 1986 made such sweeping changes to the Internal Revenue Code that the Congress chose to issue the code as a completely new edition—something that has not occurred since 1954. As a result of the act, the elderly were provided an increase in the amount of the standard deduction as well as other advantages available to the general population. Partially offsetting these benefits are the repeal of the extra personal exemption for the elderly (effective after 1987), the lowering in the medical deduction, and the end of the initial tax-free status of private pensions.

TABLE 1.—PERSONAL INCOME TAX RATES

[In percent]

1987		1988	
Taxable income	Tax rate	Taxable income	Tax rate
Married Filing Jointly:			
0 to $3,000	11	0 to $29,750	15
$3,000 to $28,000	15	$29,750 to $71,900	28
$28,000 to $45,000	28	$71,900 to $149,250 [1]	33
$45,000 to $90,000	35	Over $149,250	28
Over $90,000	38.5		
Single:			
0 to $1,800	11	0 to $17,850	15
$1,800 to $16,800	15	$17,850 to $43,150	28
$16,800 to $27,000	28	$43,150 to $89,560 [1]	33
$27,000 to $54,000	35	Over $89,560	28
Over $54,000	38.5		

[1] The benefit of the 15-percent bracket is phased out when taxable income exceeds $43,150 (single) and $71,900 (joint). The top figure for the 33-percent bracket will increase by $10,920 in 1988 for each exemption. For example, the 33-percent bracket for a family of 4 will be $71,900 to $192,930.

(1) Extra Personal Exemption for the Elderly

The extra personal exemption for elderly persons was enacted in 1948 to provide some relief from the effects of the postwar economy on the elderly. At that time, this provision removed an estimated 1.4 million elderly taxpayers and others (blind persons also were provided the extra personal exemption) from the rolls, and reduced the tax burden for another 3.7 million. Effective in 1987, the exemption is no longer available.

(2) Deduction of Medical and Dental Expenses

Under prior law, medical and dental expenses, including insurance premiums, copayments, and other direct out-of-pocket costs, were deductible to the extent that they exceeded 5 percent of a taxpayer's adjusted gross income. The 1986 tax law raised the threshold to 7.5 percent.

Since the elderly require more health care per capita than the nonelderly, the cut in the medical deduction could have a disproportionately negative impact on some elderly persons. Although persons 65 and older constitute about 12 percent of the population, their health care expenditures account for about one-third of the national total. In 1984, the annual average per capita expenditure for the elderly was $4,200, compared with $1,200 for those under 65. However, it should also be noted that the availability of Medicare lessens, to some extent, the importance of the medical deduction to elderly persons.

(3) Private Pensions

Prior to 1986, retirees under the civil service retirement system or any other contributory pension plans generally had the benefit of the so-called 3-year rule. The effect of this rule was to exempt, up to a maximum of 3 years, pension payments from taxation until the amount of previously taxed employee contributions made during the working years was recouped. Once the employee's share was recouped, the entire pension became taxable.

Under the 1986 act, the employer's contribution and previously untaxed investment earnings of the payment are calculated each month on the basis of the worker's life expectancy, and taxes paid on the annual total of that portion. Retirees who live beyond their estimated lifetime then must begin paying taxes on the entire annuity, the rationale being that the retiree's contribution has been recouped and the remaining payments represent only the employer's contribution. For those who die before this point is reached, the law allows the last tax return filed on behalf of the deceased to treat the unrecouped portion of the pension as a deduction.

With a higher taxable income, some pensioners may be pushed into a higher tax bracket as a result of the provision. However, any initial tax increases are likely offset over the long run by the tax break on the retired worker's share of the pension during his or her estimated life time.

(4) Personal Exemptions and Standard Deductions

The new tax law provides for phased-in increases in the personal exemption. In 1987, the personal exemption was increased to $1,900, which is $820 higher than in the previous year. In 1988, it will be increased to $1,950, and for years 1989 and beyond, it will be increased to $2,000.

TABLE 2.—STANDARD DEDUCTIONS BY FILING STATUS

Filing status	Standard deduction	
	Under 65 and not blind	Age 65 or older or blind
1987:		
Single	$2,540	$3,750
Married filing jointly [1]	3,760	5,600
Married filing separately	1,880	3,100
Head of household	2,540	5,150
Qualifying widow(er)	3,760	5,600
1988:		
Single	3,000	3,750
Married filing jointly [1]	5,000	5,600
Married filing separately	2,500	3,100
Head of household	4,400	5,150
Qualifying widow(er)	5,000	5,600

[1] Use 2d column if either spouse is 65 or older or blind.

(5) Filing Requirements and Exemptions

Six million additional taxpayers—many of them elderly—will be exempt from filing income tax forms under the new tax law. The law raises the levels below which persons are exempted from filing Federal income tax forms. Single persons 65 or older do not have to file a return if their income is below $5,650. For married couples filing jointly, the limit is $9,400 if one spouse is 65 or older or $10,000 if both spouses are 65 or older. Persons who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $500 or their gross income exceeds their maximum allowable standard deduction ($3,100 for persons 65 or older or blind, $3,700 for persons who are both 65 or older and blind).

(6) Repeal of Other Provisions

A number of other provisions repealed by the 1986 act also are of interest to elderly taxpayers. These include:

The dividend exclusion of up to $100 per taxpayer;

The 60 percent exclusion on capital gains (after 1986, capital gains will be treated as ordinary income);

The deductions for contributions to IRA's by taxpayers above certain income levels who participate in employer-provided pension arrangements;

The deduction for nonmortgage interest expense will be phased out through 1991;

The deduction for State and local sales tax; (not a discretionary expenditure on necessities such as groceries, medicines, and prescription drugs); and

The income-averaging method of computing income tax.

2. Issues

(A) THE IMPACT OF TAX REFORM

The full impact of the tax reform measure will not be felt by many Americans until 1990. While some provisions already have taken full effect, such as the new treatment of civil service retirement pensions, others have not. Most notably, the increases in the personal exemption are phased in through 1989.

One study prepared for the American Association of Retired Persons concludes that the 1986 tax reform measure ultimately will remove about 2 percent of the elderly from the tax rolls, and that tax payments for this age group as a whole will decline overall by about 1 percent. The study also concludes that on the whole the benefits of the new code to the elderly are substantially less than those to the nonelderly. Average tax savings are estimated at $18 and $401, respectively, for the two groups.

(B) SOCIAL SECURITY EARNING LIMITATIONS

Under current law, the working Social Security beneficiary loses $1 of benefits for every $2 earned over a specified limit. In 1988, the earnings limitation is $8,400 for the 65–69 age group (in 1990, the deduction will change to $1 for every $3 earned over the limit) and $6,120 for those under 65. For those over 69, there is no limit on earnings.

After the first year in which Social Security benefits are received, the earnings limitation is applied to total annual earnings, without regard to the number of months worked or the amount earned in any particular month. During the first year, the limits are applied on a monthly basis.

In 1987, bills were introduced to reduce or repeal the Social Security earnings limitation. Backers of this legislation have emphasized that the law discourages older men and women from working, and, when taken together with deductions, FICA and income taxes, the limitation can amount to a tax rate of 50 percent or higher. This poses particular hardships on older workers who cannot afford to retire and must continue working. In 1984, earnings accounted for one quarter of the aggregate income of older taxpayers.

Additionally, opponents of the Social Security earnings limitation have pointed out that the law discriminates against Social Security recipients with less benefits because they are subject to the same earnings ceiling as those receiving larger benefits.

On broader grounds, opponents contend that tax and public policies should encourage older men and women to continue working as long as they are willing and able. By eliminating the earnings limitation more older men and women likely would continue contributing to the economic production of the Nation.

The principal obstacle facing such proposals is financial: Over a 5-year period, the cost of repealing the Social Security earnings limitation is estimated at $16 billion. In times of record Federal budget deficits, revenue losses of this magnitude pose larger economic implications. However, under the modified proposal (discussed in chapter 2), costs would be significantly less, thus increasing the chances of congressional action.

B. SAVINGS

1. BACKGROUND

Since 1981 there has been considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: Individuals saving their personal income, businesses retaining their profits, and the Government savings when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal savings and capital accumulation recently have been enacted.

At the same time, retirement income experts have suggested that incentives for personal savings be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are dependent primarily on Social Security for their income. Thus, some analysts favor a better balance between Social Security, pensions and personal savings as sources of income for retirees. The growing financial crisis that faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their preretirement savings efforts.

The life-cycle theory of savings has helped support the sense that personal savings is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings habits are largely dependent on available income versus current consumption needs, an equation that changes over the course of most individuals' lifetimes.

The consequences of the life-cycle savings theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates: Taxpayers who are reaching maturity, earning above-average incomes and subject to relatively high marginal tax rates. Whether this group presently is responding to these incentives by creating new savings or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a trade-off of increased savings for current consumption, a behavior which they are not under most circumstances inclined to pursue. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially those at the lower end of the income spectrum.

The dual interest in increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement savings over the last decade.

However, in recent years, the Congress has begun to question the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals, and as a way to create significant net new retirement savings. These issues received attention in 1986 as part of the effort to improve the fairness, simplicity and efficiency of Federal tax incentives.

The role of savings in providing income in retirement has increased gradually over the last decade as new generations of older Americans with greater assets have reached retirement. In 1986, 26 percent of elderly income came from assets, compared with only 16 percent in 1962. Fully, 67 percent of the elderly had some income from assets in 1984, compared with 54 percent in 1962.

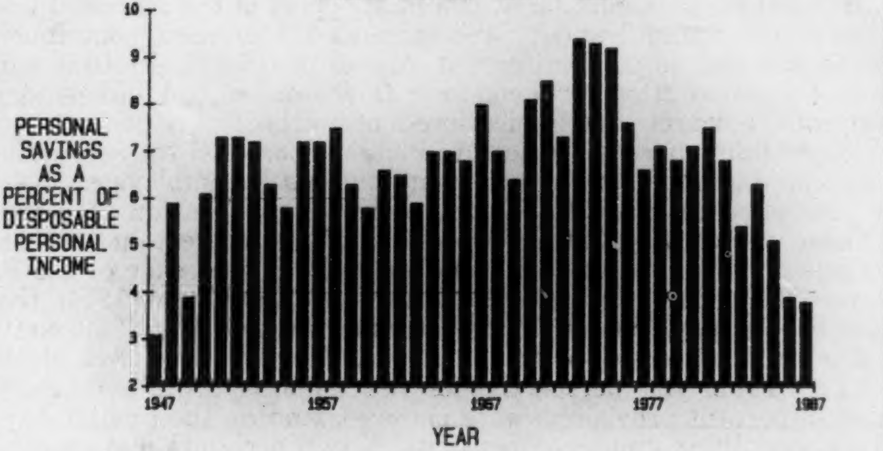
The distribution of asset income varies for different elderly subgroups. As 1986 figures indicate, the oldest old are less likely to have asset income than the younger elderly. Only 62 percent of those 80 and older had asset income in 1986, compared with 68 percent of those in the 65–69 age group. In 1986, 71 percent of elderly men had asset income, compared with 66 percent of elderly women. Whites are more than twice as likely to have asset income as other races; 71 percent of elderly whites had asset income, compared to only 30 percent for blacks and 31 percent of the elderly of Spanish origin.

Finally, the likelihood of asset income receipt is directly proportional to total income. Asset income is much more prevalent among individuals with high levels of retirement income. Only 27 percent of elderly persons with incomes less than $5,000 receive income from assets, while 84 percent of those with incomes between $10,000 and $20,000 and 95 percent of those with income over $20,000 receive some asset income. One-third of the elderly with incomes greater than $20,000 relied on assets to provide more than half of their retirement income, while only 11 percent of those with income less than $5,000 relied on assets for more than half their retirement income.

Historically income from savings and other assets has furnished a small but growing portion of total retirement income. Assets remain a far more important source of income for the retired populations on the whole than pension annuities, largely because less than one in three retirees receive pension benefits.

The effort to increase national investment springs from a perception that governmental, institutional, and personal savings rates are lower than the level necessary to support a healthy economy. Except for a period during World War II when personal savings approached 25 percent of income, the personal savings rate in the United States has ranged between 5 percent and 8 percent of disposable income. (Chart 1 shows the variation in personal savings rates as a function of disposable personal income from 1947–87.) Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families and work forces and efforts to maintain levels of consumption in the face of inflation. Personal savings rates in the United States historically have been substantially lower than in other industrialized countries. In some cases it is only one-half to one-third of the savings rates in European countries.

CHART 1
PERSONAL SAVINGS RATE
UNITED STATES: 1947 - 1987



SOURCE: National Income Product Accounts, Bureau of Economic Analysis, Department of Commerce.

For 1987, Commerce Department figures indicate that the personal savings rate was 3.8 percent, about the same as 1986. For the third and fourth quarters of 1987, the rates were 2.8 percent and 4.5 percent, respectively. Analysts suggest that without savings in corporate pensions, the country actually experienced a decline in savings overall. In part, this dramatically low figure may reflect an increased tendency to purchase goods on consumer credit. Given the additional expansion of tax incentives for retirement savings in recent years, the low rate of personal savings raises serious doubts about the effectiveness of those incentives. If retirement savings only take place in employer-sponsored plans, then policy analysts argue that retirement income goals might be better served by policies favoring these, rather than individual savings vehicles.

Even assuming present tax policy creates new personal savings, critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute savings as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal savings being generated. Under this analysis net national savings would be increased only when net new personal savings exceeded the Federal tax revenue foregone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently been placed on tax incentives to encourage savings in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy issued in 1981 recommended several steps to improve the adequacy of retirement savings, including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for Individual Retirement Accounts (IRA's). In that same year, the Committee for Economic Development, an independent, nonprofit research and educational organization, issued a report which recommended a strategy to increase personal retirement savings that included tax-favored contributions by employees covered by pension plans to IRA's, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. In each Congress since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, there have been expansions in tax-preferred savings devices. This continued with the passage of the Economic Tax Recovery Act of 1981 (ERTA). From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRA's, simplified employee pensions, Keogh accounts and employee stock ownership plans (ESOP's). ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined-contribution plans.

The evolution of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important implications for tax-favored retirement savings. When there is increasing competition for Federal tax expenditures the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

2. Issues

(A) INDIVIDUAL RETIREMENT ACCOUNTS (IRA'S)

(1) Pre-1986 Tax Reform

The extension of IRA's to pension-covered workers in 1981 by ERTA resulted in dramatically increased IRA contributions. In 1982, the first year under ERTA, IRS data showed 12.1 million IRA accounts, nearly four times the 1981 number. In 1983, the number of IRA's rose to 13.6 million, 15.2 million in 1984, and 16.2 million in 1985. In 1986, contributions to IRA's totalled $38.2 billion. The Congress anticipated IRA revenue losses under ERTA of $980 million for 1982 and $1.35 billion in 1983. However, according to Treasury Department estimates, revenue losses from IRA deductions for those years were $4.8 billion and $10 billion, respectively. By 1986, the estimated revenue loss had risen to $16.8 billion. Clearly, the program had become much larger than Congress anticipated.

The rapid growth of IRA's posed a dilemma for employers as well as Federal retirement income policy. The increasingly important role of IRA's in the retirement planning of employees began to diminish the importance of the pension bond which links the interests of employers and employees. Employers began to face new problems in attempting to provide retirement benefits to their work forces.

A number of questions arose over the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional savings or does it merely redirect existing savings to a tax-favored account? Third, are IRA's retirement savings or are they tax-favored savings accounts used for other purposes before retirement?

Evidence indicated that those who used the IRA the most might otherwise be expected to save without a tax benefit. Low-wage earners barely used IRA's. The participation rate among those with less than $20,000 income was two-fifths that of middle-income taxpayers ($20–$50,000 annual income) and one-fifth that of high-income taxpayers ($50,000 or more annual income). Also, younger wage earners, as a group, were not spurred by the IRA tax incentive. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.

Though a low proportion of low-income taxpayers utilize IRA's relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers apparently are more often motivated to contribute to IRA's by a desire to reduce their tax liability than to save for retirement.

One of the stated objectives in the creation of IRA's was to provide a tax incentive for increased savings among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive. As a matter of tax policy, IRA's could be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue was whether all IRA savings are in fact retirement savings or whether IRA's were an opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited from tapping the money by the early 10-percent penalty on withdrawals before age 59½. However, those who do not intend to use the IRA to save for retirement, can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA, that occurs because the earnings are not taxed will surpass the value of the 10-percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings emphasized the weakness of the penalty and promoted IRA's as short-term tax shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

An additional concern is that the IRA was not equally available to all taxpayers who might want to save for retirement. Nonworking spouses of workers saving in an IRA could contribute only an additional $250 a year. Some contended that this created an inequity between two-earner couples who could contribute $4,000 a year and one-earner couples who could contribute only $2,250 in the aggregate. They argued that it arbitrarily reduces the retirement income of spouses, primarily women, who spend part or all of their time out of the paid work force. Those who opposed liberalization of the contribution rules contended that any increase would primarily advantage middle- and upper-income taxpayers, since the small percentage of low-income taxpayers who utilized IRA's often did not contribute the full $2,000 permitted them each year.

(2) Post-1986 Tax Reform

The IRA provisions of the 1986 Tax Reform Act were among the most significant changes affecting individual savings for retirement. To focus the deduction more effectively on those who need it, the act repealed the deductibility of IRA contributions for pension plan participants and their spouses, with an adjusted gross income (AGI) in excess of $35,000 (individual) or $50,000 (family). For pension-covered workers and their spouses with AGI's between $25,000 and $35,000 (individual) or $40,000 and $50,000 (family) the maximum deductible IRA contribution is reduced in relation to their incomes. Workers in families without pensions, and pension-covered workers with AGI's below $25,000 (individual) and $40,000 (family) retain the $2,000 per year IRA contribution. Even with the loss of the IRA deduction for some workers, however, all IRA accounts, even those receiving only after-tax contributions, continue to accumulate earnings tax free.

(B) EMPLOYEE STOCK OWNERSHIP PLANS (ESOP'S)

(1) Pre-1986 Tax Reform

Employee stock ownership plans were promoted as a means for transferring the ownership of a company's capital to its workers. Although ESOP's can become a valuable source of retirement income to supplement Social Security, pension benefits and personal savings, they are not designed (or intended) to be an employee's sole or primary retirement savings vehicle, or a replacement for a traditional pension arrangement. Such a plan can offer an employee a potential investment return exceeding that of a standard pension plan if the company is growing at a substantial rate or is consistently profitable.

However, under an ESOP, an employee not only bears the risk of the plan's investment performance, but also the additional risk of relying on a nondiversified investment portfolio. As the value of a company's shares can fluctuate over a wide range in response to the employer's fortunes, an ESOP cannot be considered a secure primary retirement vehicle for participants. In recent years, there was considerable concern when some corporations terminated their defined benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans was their expanding use in closely held corporations, where the value of the stock to employees is uncertain. For employees to have meaningful ownership interest in their employer through participation in an ESOP, the stock must be fairly valued and the employees must have some control over the way in which the stock is voted. But in a privately held corporation, one or both of these elements may be missing or constrained. It is difficult to value ESOP-contributed stock of a privately owned corporation because there is no ready market for its resale. This creates an enormous potential for abuse. By overvaluing stock contributions an employer-owner can inflate the tax benefit received while employees may be hurt because the real value of the stock is less than its nominal worth.

Although Congress clearly had expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives, which form the basis of congressional policy, became debatable. In the case of ESOP's in closely held corporations with limited voting rights passthrough, the absence of voting rights and of a ready market for resale, cast doubt on the existence of any realistic incentive at all. Even in publicly traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulate fast enough compared to the total amount of stock outstanding to give employees any significant voice in corporate decisionmaking. As a result, several employee organizations opposed the implementation of ESOP's unless coupled with representation on the employer's board of directors.

The ESOP concept had been supported by the Congress in spite of these unresolved issues. It is important to note, however, that since an ESOP's value is inextricably tied to the financial health of the employer, their implementation should be traded off against current wages rather than retirement benefits when being used to save financially distressed employers. If an ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income as well. However, by exchanging the ESOP for current wages, an employee's retirement benefit remains insulated to some degree from the consequences of the employer's potential demise, while a much stronger link is forged between productivity incentives and the employee's present compensation.

(2) Post-1986 Tax Reform

The Tax Reform Act of 1986 significantly affected ESOP's, both in their taxation and the manner in which they may be managed. Generally, the new rules were aimed at increasing the attractiveness of ESOP's and the protections available to participating workers.

To reduce the risk associated with ESOP's, the act requires that partial diversification of a plan for workers nearing retirement be allowed. As a result, a worker at 55 with at least 10 years of service may diversify up to 25 percent of his or her account. At age 60, the amount which can be reinvested in other securities increases to 50 percent. At least three investment options must be provided.

In addition, the act shortened the period within which distributions to participants must be made. Under current law, unless the retired worker elects otherwise, distributions must begin no later than 1 year after retirement, disability, or death.

The 1986 law also established a number of tax incentives, including an estate tax deduction of 50 percent of the proceeds from a sale of an ESOP's assets. The deduction is effective for estate sales through 1991.

(C) RESIDENTIAL RETIREMENT ASSETS

(1) Pre-1986 Tax Reform

Tax incentives which long have promoted the goal of home ownership include the income tax deductions for real estate taxes and home mortgage interest. As in the one-time exclusion of capital gains on the sale of a home, these tax breaks recognize that for many elderly persons a home may represent their principal or only retirement asset.

(2) Post-1986 Tax Reform

Prior to the 1986 Tax Reform Act, all real estate mortgage interest was tax deductible. To generate new Federal revenues, the act limited the deduction to interest on home mortgages, home equity loans taken out on a principal residence or a second home to purchase a home, make home improvements, or pay medical or educational expenses. Thus, interest paid on any part of the loan used for other purposes no longer qualified for the deduction. (The deduction for real estate taxes remains unchanged.)

The home mortgage interest deduction was further restricted under the Omnibus Budget Reconciliation Act of 1986 (Public Law 100-203). The act placed a ceiling on the amount of a mortgage that qualifies for the tax deduction. For loans used to acquire or improve a principal or second residence, the limit is $1 million. For home loans used for other debt purposes (limitation to medical or educational debts eliminated), the cap is $100,000.

C. PROGNOSIS

In coming years, the full impact of the 1986 Tax Reform Act will unfold. On the one hand, the elimination of the additional tax exemption for the elderly and the lowering of the medical deduction will be sources of concern for some elderly taxpayers. On the other, increases in the personal exemption and the additional increase in the standard deduction will provide clear tax advantages.

Most likely, the new rules will have a mixed effect on the elderly. Some may be dropped from the tax rolls, while others may pay additional taxes. Some may pay reduced taxes, while others may pay the same as before. In 1988, elderly men and women will nervously await determination of their 1987 tax liability and the comparison of it with their previous year's liability. That comparison will continue each year during the phase-in of the 1986 provisions.

The extent to which the considerable benefits under the 1986 act fail to offset potential losses from less advantageous changes, certain tax provisions may be a scurce of controversy. However, the massiveness of the 1986 tax overhaul make unlikely any significant tax or savings incentive legislation in 1988 or soon thereafter.

As in the past, the Federal tax and savings policy will continue to take into account the vulnerable financial status of many older Americans in their post-working years. At the same time, broader financial concerns, particularly the need to reduce the Federal budget deficit, can be expected to play an increasing role in future debates in this area.

Chapter 5

EMPLOYMENT

OVERVIEW

Concurrent with the rapid aging of the U.S. population has been the dramatic lengthening of the time older Americans spend in retirement. Not only are people living longer, but many are choosing to retire at a much earlier age. In fact, early retirement is a concept which is fast becoming imbedded into the American consciousness. Those who wish or need to continue working, however, often come up against barriers of age discrimination.

Age, like race, sex, religion, and national origin, is a protected category under Federal statutes. Eliminating age bias in the workplace is consistent with a tradition in America of struggle against arbitrary policies which discriminate against individuals because of their basic beliefs or their personal characteristics. The nearly unanimous opposition to mandatory retirement policies by the American public is one indicator of the strong sentiment against arbitrary age bias in employment. Yet, despite these civil rights arguments, the protections against age discrimination remain incomplete and somewhat ineffectual.

Despite legal protections, many workers continue to be forced into retirement either by unscrupulous employers, or due to their inability to find employment. Complaints of age discrimination filed with the Equal Employment Opportunity Commission have increased dramatically during the past several years, from 11,076 in fiscal year 1980 to 17,443 in fiscal year 1986.

While the unemployment rate for older workers is approximately half of that for their younger counterparts, once an older person loses a job, his or her duration of unemployment is much longer. Whereas someone aged 20 to 24 experiences an average unemployment duration of 9.5 weeks, the average for a job seeker 55 to 64 years of age is 23.2 weeks.

Among the more elusive forms of discrimination is in the area of hiring. During a job search, older persons are often confronted with interviewers much younger than themselves. Some interviewers feel intimidated about hiring someone who is 20 or 30 years their senior. In addition, many older job applicants are consistently informed that they are "over-qualified." Because of this, many feel they must lie about their age and experience in order to find employment.

A. BACKGROUND

1. Age Discrimination

Numerous obstacles to older worker employment exist in the labor force. These include: (1) Negative stereotypes about aging and productivity; (2) job demands and schedule constraints which are inconsistent with the skills and needs of older workers; and (3) policies which make it undesirable to remain in the labor force, such as early retirement incentives and, until recently, discontinued pension credits. Several of these obstacles have their roots in age discrimination.

Age discrimination in employment plays a pernicious role in blocking employment opportunities for older workers. The development of retirement as a social pattern in industry may have served to enhance and legitimize employment discrimination practices. Indeed, retirement is a concept which has become imbedded in the American philosophy.

Today, age discrimination in employment is widespread. There is no agreement on the exact nature of the problem, nor is there a consensus on how to solve it. But few would disagree that the problem is real and that it affects the lives of millions of Americans.

Younger workers, rather than older workers often receive needed skills training to keep up with technological change. This can result from an employer's ill-conceived notions that it is financially more advantageous to train a younger employee than his or her older counterpart. Certain employers believe that a younger employee will remain on the job longer, simply because of his or her age. However, the mobility of today's work force does little to guarantee the greater employment longevity of a younger worker. In fact, according to the Bureau of Labor Statistics (BLS), the median job tenure for current employees is 4.2 years.

Other discriminatory practices include the relocation of older employees to entirely new areas in hopes that they will simply resign, rather than move to an undesirable location. Other employers begin to give their older employees poor evaluations for no good reason other than to provide themselves with the opportunity to let them go.

Despite Federal legislation to ban most forms of age discrimination from the workplace, most Americans believe age discrimination remains a serious problem. Two nationwide surveys by Louis Harris & Associates—one in 1975, the other in 1981—found nearly identical results; 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work."

The perception of widespread age discrimination held by the public is shared by a majority of business leaders. Most employers believe age discrimination exists, according to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc. The following key points summarize the survey's findings:

—61 percent of employers believe older workers today are discriminated against in the employment marketplace;

—22 percent claim it is unlikely that, without the present legal constraints, the company would hire someone over age 50 for a position other than senior management;

—20 percent admit that older workers (other than senior executives) have less of an opportunity for promotions or training; and

—12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

The pervasive belief that all abilities decline with age has fostered the myth that older workers are less efficient than younger workers. This myth has no basis in fact. While it is clear that we have not yet succeeded in changing the attitude that older workers hinder management efforts to improve productivity, there is growing recognition of their value.

A study of Waldman and Avolio, published in the February 1985 issue of the Journal of Applied Psychology, revealed little support for the "somewhat widespread belief that job performance declines with age." The researchers found a strong correlation between performance improvements and increasing age, especially in objective measures of productivity. They found that "although chronological age may be a convenient means for estimating performance potential, it falls short in accounting for the wide range of individual differences in job performance for people at various ages."

Employers report that older workers stay on the job longer than younger workers. They are also perceived to offer experience, reliability, and loyalty. An AARP survey of 400 businesses in 1985 revealed that, in general, older workers are perceived very positively, and that they are particuarly valued for their experience, knowledge, work habits, and attitudes. The survey showed that, contrary to popular belief, employers give older workers their highest marks for productivity, as well as for attendance, commitment to quality, and satisfactory work performance. A surprising 90 percent believe that older workers are cost-effective and the overwhelming majority believe that the cost of older workers is justified when their value to the company is considered.

Corporate-age discrimination can result in loss of valuable experience, mature judgment, and priceless know-how. Attitudes toward older workers are changing, but as the rise in the manner of ADEA charges filed attests, much more must be done to provide fair opportunities in employment and retirement for older workers.

The forms of age discrimination range from the more obvious mandatory retirement ages, to more subtle job harassment and early retirement incentives. Each of these represent not only a threat to the well-being of older individuals, but also undermine the economic stability of the Nation's retirement income systems and, to a lesser extent, the larger economy. While the number of people getting maximum Social Security benefits is increasing, most retirees get less than the maximum. Census Bureau data as of March 1986 shows that of the 27,422,000 people aged 65 and above, approximately 16,955,000 had a total annual monetary income of less than $10,000. Only slightly more than half of those currently in the work force are covered by a private pension plan and most people 65 and over do not have substantial holdings in savings, stocks, insurance policies, and bonds.

According to a 1986 report of the National Commission for Employment Policy several million older workers suffered severe labor market problems (low income and unemployment or underemployment) in 1980. Unemployment is a particularly serious problem for those elderly persons who have to work for economic reasons or who desire to stay active. In 1984, 315,000 Americans age 60 and over (97,000 of whom were age 65 or over) were out of work. These numbers are not large when compared to younger age groups, but because duration of unemployment is longer among older workers and discouraged older workers are not included in these statistics, the official unemployment rate is not an accurate indicator of the seriousness of the problem.

Older workers who have lost their jobs have more difficulty in obtaining other jobs and stay out of work longer than younger persons. In fact, persons age 55 to 64 have the longest spells of unemployment of any group in the country.

According to the BLS, because an older worker is likely to be unemployed for a longer period than a younger employee, he or she is also more likely to exhaust available unemployment insurance benefits, thereby suffering economic hardships. Additionally, the 1978 Employment and Training Report of the President states that the problems of older unemployed workers are worsened by the fact that many persons over 45 may still have significant financial obligations.

Discouraged workers are those who report that they want a job but are not looking because they believe that they cannot find one. There is evidence that the longer periods of unemployment experienced by older workers often lead to early involuntary retirement as they quit searching for employment and become "discouraged" workers. Older workers disproportionately experience labor market discouragement. For men age 65 and over, the annual average level of discouraged workers is almost as large as the number of unemployed. The BLS reports that the prospects of an older male worker finding work are so low that he is three times more likely to become discouraged and withdraw from the work force than his younger counterpart.

When older workers are fortunate enough to find work, they generally face a cut in earnings in a new job and suffer a decline in status compared to their previous employment. Psychologists report that such workers can face wrenching psychological stress—they can experience hopelessness, depression, and frustration. Following retirement, many people experience financial difficulties because of decreased income which often accompanies retirement, difficulty in finding reemployment, longer life spans, erosion of fixed pensions by inflation, and reduced private pension benefits as a result of forced retirement.

Finally, medical evidence suggests that forced retirement can adversely affect a person's physical, emotional, and psychological health. It may even affect his or her life span. According to the AARP, 30 percent of the country's retirees are believed to suffer serious adjustment problems.

Thus, age discrimination reduces the work efforts of older people, encourages premature labor force withdrawal, and increases the load on an already burdened Social Security system and on private pensions. Without adequate solutions to the problems of age workers to remain employed longer, the Nation could be facing serious future economic and social crisis.

(A) THE AGE DISCRIMINATION IN EMPLOYMENT ACT

This year marks the 20th anniversary of enactment of the Age Discrimination in Employment Act of 1967 (ADEA). The act arose, in large part, from a 1964 Executive order issued by President Johnson specifically declaring a public policy against age discrimination in employment. Three years later, the President called for congressional action to eliminate age discrimination. This resulted in the passage of the ADEA in December of 1967 (Public Law 90-202).

The ADEA became effective on June 12, 1968. The act was the culmination of years of debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the competing interests of the right of the older worker to be free from age discrimination in all aspects of employment, and the employer prerogative to control the managerial decisions which make a business profitable. The provisions of the ADEA attempt to balance these competing interests by prohibiting age discrimination based upon an employer's arbitrary policies which would prevent employment of individuals above a certain age. Arbitrary age limits may not be used as conclusive determinations of nonemployability, so that employment decisions regarding older persons should be based on an individual assessment of each applicant's or employee's potential or ability.

Specifically, the ADEA was enacted "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act originally prohibited employment discrimination against persons aged 40 to 65. The upper age limit was set at 65 because it was the common retirement age in U.S. industry and the normal eligibility age for full Social Security benefits. In 1978, the act was amended to protect persons up to age 70. These age limits were chosen to focus coverage on workers especially likely to experience job discrimination. Mandatory retirement was all but eliminated by the Age Discrimination in Employment Act Amendments of 1986. The 1986 amendments eliminated the age 70 "cap" for workers over 40 in all but a select few professions.

The act specifies that actions otherwise deemed unlawful may be permitted if they are based upon the following considerations:

> Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business;
>
> Where differentiation is based on reasonable factors other than age (for example, the use of physical examination relating to minimum standards reasonably necessary for specific work to be performed on a job);
>
> To observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority

system or benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and

Where an employee is discharged for good cause.

In addition, an executive or high-ranking, policymaking employee in the private sector entitled to annual private retirement benefits of at least $44,000 could be compulsorily retired at age 65, simply because of age. This is known as the "executive exemption" and it was designed to allow turnover at the top levels of the organization. While is has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

The ADEA has been amended a number of times since it's enactment in 1967. The first set of amendments occurred in 1974, when the provisions of the act were extended to include Federal, State, and local government employers. The number of workers covered was also increased by exempting only those employers with fewer than 20 employees. Previous law exempted employers with 25 or fewer employees. In 1978, the act was amended to extend protection to age 70 for private sector, State, and local government employers, and by removing the upper age limit for employees of the Federal Government. Regulations implementing the 1978 amendments, however, specified that employers are not required to credit years of service worked beyond age 65 to final pension benefit levels. Congress responded in 1986 by further amending the act to require post-age 65 pension accruals.

The ADEA was amended in 1982 by a provision included in the Tax Equity and Fiscal Responsibility Act (TEFRA). This provision, referred to as the "working aged" clause, requires employers to retain their over-65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. Now, the situation is reversed, with Medicare acting as the payer of last resort. This provision was desigend to be a cost saver for the Medicare Program, but it is viewed as a new obstacle to employment for older workers because it increases the costs of employment and, for many small companies, there are serious problems in finding insurance coverage at all for these older workers.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act. Public Law 98-459, section 11(f), amended the ADEA by extending protections to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation was based in part on the belief that many such workers are really an extension of the U.S. work force who should not be subject to possible age discrimination just because they are assigned abroad. Section 12(c)(1) of the ADEA, the executive exemption, was also amended by raising, from $27,000 to $44,000, the annual private retirement benefit level for determination of exemption from provisions of the act for persons in bona fide executive or high policymaking positions. As will be discussed in detail below, major amendments to the act were enacted in 1986, during the final days of the 99th Congress.

(B) THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

The Equal Employment Opportunity Commission (EEOC) is responsible for enforcing laws prohibiting discrimiation. These include: (1) Title VII of the Civil Rights Act of 1964; (2) The Age Discrimination in Employment Act of 1967; (3) The Equal Pay Act of 1963, and; (4) Sections 501 and 505 of the Rehabilitation Act of 1973.

When originally enacted, enforcement responsibility for the ADEA was placed with the Department of Labor (DOL) and the Civil Service Commission. In 1979, Congress enacted President Carter's Reorganization Plan No. 1, thus transferring responsibilities for ADEA administration and enforcement to the EEOC effective July 1, 1979.

Since taking over responsibility for the ADEA, the Commission has alternatively been praised and criticized for its enforcement performance. During fiscal year 1986, the EEOC received 17,443 ADEA complaints, in increase of more than 30 percent over the 11,076 claims for fiscal year 1980. While the number of lawsuits filed has increased, critics complain that the EEOC is moving away from broad complaints against large companies and entire industries in favor of more narrowly focused cases involving few individuals. Critics maintain that while the number of ADEA charges filed has grown dramatically, EEOC's litigation record has not nearly matched this increase in complaints. In fact, while EEOC data indicate the filing over 100 suits in fiscal year 1986, data for fiscal year 1987 indicate 80 suits filed.

It appears that age discrimination complaints will only continue to rise. In 1980, one-fifth of the U.S. population was over 55 years old. Demographic statistics project that this figure will climb to approximately 25 percent by the year 2000. While the total U.S. population is expected to increase by one-third between 1982 and 2050, the older population (aged 55 and older) is expected to increase 113 percent. Eventually, this demographic trend is expected to mature the U.S. work force and this will mean greater competition among older and middle-age workers.

In the early eighties, the recession caused employers to search for easy ways to reduce their payrolls and to bring in younger, less expensive workers. In firms where younger workers were already laid off, further reductions had to come from older workers. Plant closings have also resulted in large numbers of displaced older workers. In addition, companies anxious to accommodate the baby boom generation will come under increasing pressure to find vacancies for them. The House Select Committee on Aging has estimated that the elimination of mandatory retirement will add about 840,000 workers age 70 and over to the 28 million workers aged 40 to 70. This represents a 3 percent increase in the number of individuals protected against age discrimination in employment and may also contribute to a greater caseload at the EEOC.

2. FEDERAL PROGRAMS

The Federal Government provides funds for training disadvantaged and dislocated workers to assist them in becoming more employable. Two important Federal programs designed to promote the employment opportunities of older workers are the Job Training Partnership Act (JTPA) program and the Senior Community Service Employment Program (SCSEP) under title V of the Older Americans Act.

(A) THE JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act enacted by the 97th Congress, and which went into effect October 1, 1983, establishes a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. For the program year from July 1, 1988 through June 30, 1989, $3.75 billion has been appropriated for JTPA programs as part of the fiscal year 1988 appropriations act (Public Law 100-202). This compares to the $3.67 billion appropriated for JTPA in fiscal year 1987.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the title II-A program, which authorizes training for disadvantaged youth and adults, funds are allotted among States according to the following three equally weighted factors: (1) Number of unemployed individuals living in areas with jobless rates of at least 6.5 percent for the previous year; (2) Number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the number of economically disadvantaged individuals. Training under title II-A can include on-job training, classroom training, remedial education, employability development, and a limited amount of work experience. For the period July 1, 1985 through June 30, 1986, about 11,888 persons 55 and older participated in the title II-A program, representing 3 percent of total participants.

Section 124(a-d) of JTPA also establishes a statewide program of job training and placement for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their title II-A allotments for this older workers program. The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns.

For workers who have been or are about to be laid off, are eligible for or have exhausted their entitlement to unemployment compensation and are unlikely to return to their previous occupation or industry, Congress created title III. The dislocated workers program is administered by the States and includes such services as job search assistance, job development, training in job skills for which demand exceeds supply, relocation assistance and activities conducted with employers or labor unions to provide early intervention in case of a plant closing. During the period between July 1, 1985 and June 30, 1986, approximately 9,000 persons 55 and over were served by the title III program (about 8 percent of total program terminations).

According to the final draft of recommendations released in 1987 on-job training, the JTPA is working well and, with minor exceptions, is meeting its legislative mandate. The report, issued by the National Commission for Employment Policy (NCEP), an independent Federal Government panel appointed by the President, however, was criticized for glossing over many problems. The report did acknowledge that conversations with State Job Training Coordination Council chairs confirmed that some States are having difficulty using the 3 percent set-aside funds for older workers due to recruitment problems and difficulty in placing this population. In testimony presented to Congress, the NCEP recommended increased funding for JTPA because the current programs can aid less than 10 percent of all eligible low-income persons and dislocated workers, including older workers.

While the impact of JTPA on mature and older workers is probably minimal, the need for and importance of JTPA is underscored by a November 1984 Department of Labor study on displaced workers. According to the study, 5.1 million workers lost their jobs due to the decline of an industry or a plant closing between 1979 and 1984. The chance of reemployment for these displaced workers declined significantly with age. Only 41 percent of those between 55 and 64 were able to reenter the labor force in any capacity (as compared to 70 percent for those between the ages of 20 and 24). Only 21 percent of those over 65 became reemployed and of those who found a job, almost half (45 percent) received lower pay than at their previous position and one-third took salary cuts of more than 20 percent. The study showed that the older an individual was when he or she lost a job, the longer he or she would be unemployed and the more likely he or she would become completely discouraged and drop out of the labor force altogether. Overall, there are more than 1.2 million "discouraged" workers in the Nation.

During 1987, both the House and Senate acted on proposals to replace title III of JTPA and related activities under the Trade Act with a worker adjustment assistance program. Both of these measures to aid dislocated workers were incorporated into the trade legislation passed by each body (H.R. 3 and S. 1420) which continued to be debated by a conference committee in the first months of 1988. The House and Senate versions include several differences, among the most important of which involves plant closings. While the Senate bill provides for advance written notice of closings and mass layoffs by the company to employees, the State dislocated worker unit, and the affected local government, the House version does not. These and other issues must be resolved during 1988 for the trade legislation to become law.

(B) TITLE V OF THE OLDER AMERICANS ACT

The Senior Community Service Employment Program (SCSEP) was given statutory life under title IX of the Older Americans Comprehensive Services Amendments of 1973. Its purpose is "to promote useful part-time opportunities in community service activities for unemployed low income persons." The program responds to certain identified needs of older persons by providing opportunities for part-time employment and income. It also serves as a source of labor for various community service activities and can assist unemployed older persons in moving into permanent unsubsidized employment. Amendments passed in 1978 redesignated the program as title V of the Older Americans Act and it was reauthorized through fiscal year 1987 by Public Law 98-459, the Older Americans Act Amendments of 1984. The act was again reauthorized during 1987.

The program is administered by the Department of Labor (DOL), which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program are those who are 55 years of age and older (with priority given to persons 60 years and older), who are unemployed, and whose income level is not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services (DHHS). Enrollees are paid the lesser of the Federal or State minimum wage or the local prevailing rate of pay for similar employment. Federal funds may be used to compensate participants for up to $13,000 of work per year, including orientation and training. Participants work an average of 20–25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

In recent years, the Reagan administration has made a number of proposals which would have significantly altered the Older Americans Act's employment focus. These have ranged from proposals to completely eliminate the title V program to proposals to change the administrative and program structure by transferring all or a portion of the program from DOL to DHHS, and to replace the subsidized job concept with one which would assist older persons to create their own business. All of these proposals were ultimately rejected by Congress which has supported the title V program in its current form and which has voted for program expansion by increasing appropriations more than 20 percent from its 1980 level.

The SCSEP is one of the few remaining direct job creation programs since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment programs. Nearly 80 percent of the participants are age 60 or older, and nearly half are age 65 or older. Over 60 percent are females, half have not completed high school, and over 85 percent have a family income below the poverty line.

The SCSEP has seen steady increases in funding and participant enrollment since its inception. In the 1968–69 program year, the first full year of its operation in a form similar to the current program, participant enrollment was 2,400 with a budget of $5.5 million. In program year July 1, 1988 to June 30, 1989, title V funding appropriations are $331 million. This includes $258,383,000 for national contracts and $72,877,000 for State grants. The fiscal year 1988 appropriation represents a funding decrease of $4.7 million from fiscal year 1987. This will result in reduction of more than 900 positions; from 65,741 in the current program year to 64,813 from July 1, 1988 to June 30, 1989.

In recent years, the program has received generally positive reviews. In fiscal year 1986, three reports were issued on a 1-year evaluation of SCSEP. One report provided information on four additional mechanisms whose use would tend to increase community service employment opportunities. A second report analyzed the success of the regular SCSEP program in fostering useful, part-time community service activities for the target population. The third report compared the experimental SCSEP projects with the regular SCSEP in regard to demographic characteristics, training provided, and levels of post-program unsubsidized employment. These reports not only confirmed the general success of the program, but also provided useful suggestions for future improvements.

3. AGE DISCRIMINATION IN EMPLOYMENT AMENDMENTS OF 1986

The House of Representatives passed H.R. 4154, the Age Discrimination in Employment Amendments of 1986, on September 23, 1986. The bill contained many important changes, including the elimination of the age 70 mandatory retirement cap for workers in all but a few professions. During subsequent Senate debate, concerns focused on such issues as a House provision to permanently allow forced retirement for public safety officers, as well as the bill's treatment of tenured university faculty. In the closing days of the 99th Congress, compromise agreements were reached that finally permitted unanimous Senate passage of a modified version of H.R. 4154 on October 23, 1987. The legislation was signed by the President on October 31, 1986.

(A) MANDATORY RETIREMENT

When first enacted in 1967, the Age Discrimination in Employment Act covered workers aged 40 to 65. In 1978, the mandatory retirement age was raised to 70. Finally, the Age Discrimination in Employment Amendments of 1986 (Public Law 99-592) eliminated mandatory retirement effective January 1, 1987. The ADEA now protects virtually all employees 40 years of age or older.

By removing the upper age limit, Congress sought to protect workers age 40 and above against discrimination in all types of employment actions, including forced retirement, hiring, promotions, and terms and conditions of employment. Currently, there are more than 2.9 million Americans age 65 and over in our work force. Many of these people want to continue working—sometimes for reasons of self-fulfillment, but more often for reasons of economic necessity. Until the passage of the 1986 amendments, Federal law deprived these people of the same guarantees of equal opportunity in employment that other citizens enjoy.

The most clearcut form of age discrimination is forced retirement rules. Depsite this fact, the mandatory retirement cap persisted for a variety of reasons. Many employers perceive older workers to be ill-suited for certain jobs because of declining mental and physical capacity, an inability to learn, a lack of creativity, and inflexibility. Vast amounts of research on the abilities of older workers, however, consistently refute these employer-held stereotypes.

By eliminating mandatory retirement, Congress acknowledged the inequities involved in judging a person's job qualifications solely on the basis of age and that chronological age alone is a poor predictor of ability to perform a job. Arguments for eliminating mandatory retirement include: (1) Older workers discriminated against may lose income; (2) the loss of status associated with the loss of a job may result in the deterioration of mental and physical health for the older person; (3) the loss of skills and experience from the work force due to mandatory retirement results in a loss to our Nation's productivity and gross national product; and (4) allowing workers to stay on their jobs longer helps the financial status of the Social Security and other retirement systems because payment of full retirement benefits is deferred until a later age and continued contributions will flow into these programs.

Employers and others in favor of retaining mandatory retirement argued that older persons, as a group, may be less well-suited for some jobs than younger workers because declining physical and mental capacity are found in greater proportion among older persons and because they do not learn new skills as easily as younger persons. Other arguments against eliminating mandatory retirement included: (1) Mandatory retirement preserves the dignity of the older worker who is no longer capable of performing his or her job adequately, and who would otherwise be singled out for discharge in a personally damaging proceeding; (2) mandatory retirement provides a predictable situation allowing both management and employees to plan for the future; (3) older workers can often retire with Social Security or other retirement income, making jobs (and promotions) available to younger workers who do not have other income potential; and (4) by opening up jobs, mandatory retirement also provides more opportunities to women and minorities who are under-represented in certain occupations.

In response to the argument that eliminating mandatory retirement entirely would unfairly prevent younger people from moving up the ladder, a DOL study has shown that abolishing mandatory retirement would not result in displacing women and members of racial minorities. The DOL found that the rise in permissible mandatory retirement age to 70 resulted in only negligible effects on women, minorities, and youth, and that abolishing mandatory retirement would have a similarly minimal impact. The DOL studies refuted the idea that an increased number of older workers would significantly delay promotions for younger workers. One study reported by the House Select Committee on Aging states that a 10-percent increase in the labor force participation rates of men age 65 and over would delay, on average, promotions at the highest ranks by only 6 months, while at the lower ranks, individual promotions would be retarded by approximately 5 to 10 weeks. Similarly, simulations conducted by the Urban Institute suggest that the fear that eliminating the mandatory retirement age altogether would seriously affect job opportunities for younger workers is unfounded.

(B) TENURED FACULTY EXEMPTION

Much debate exists over whether the uniqueness of the tenure system in institutions of higher education should earn it special treatment under the law and whether the mandatory retirement of tenured faculty serves the national interest. During consideration of the 1986 amendments to the ADEA, several legislative proposals were made to allow mandatory retirement of tenured faculty. In the end, a compromise allowing for a temporary exemption was reached.

The exemption allows institutions of higher education to set a mandatory retirement age of 70 years for persons serving under tenure at institutions of higher education. This provision is in effect for 7 years, until December 31, 1993. The law also requires the EEOC to enter into an agreement with the National Academy of Sciences to conduct a study to analyze the potential consequences of the elimination of mandatory retirement for institutions of higher education. The study findings are to be submitted to the President and to Congress within 5 years of enactment. The law sets forth the composition of the study panel to include administrators and teachers or retired teachers at institutions of higher education.

Most agree that the tenure system is different from many other employment situations. Tenure protects academic freedom by prohibiting dismissals except under specific conditions. Many adminstrators suggest that without a defined end to this employment, through the tenure contract and by way of the mandatory retirement age, educational institutions would be forced to end the tenure system and these protections to academic freedom and excellence.

Many have argued that without mandatory retirement at age 70, institutions of higher education will not be able to continue to bring in "fresh blood" or the intellectual surge needed to maintain excellence. It is argued that planning for the institution and its faculty needs would be undermined by the increase in otherwise retired faculty which would occur if the age 70 cap were to be lifted. The older faculty, it is claimed, would prohibit the institution from hiring younger teachers who, with their current state of knowledge, are better equipped to serve the needs of the school. The argument continues that allowing older faculty to teach or research past the age of 70 denies women and minorities access to the limited number of faculty positions.

Opponents of the exemption claim that there is little statistical proof that older faculty keep minorities and women from acquiring faculty positions. Indeed, they cite statistical information gathered at Stanford University and analyzed in a paper by Allen Calvin which suggests that even with mandatory retirement and initiatives to hire more minorities and women, there was only a slight change in the percentage of minority and women faculty on the tenure track and holding tenured faculty positions, but there is no definitive link to keeping older faculty employed.

Proponents of an exemption cite a study by the DOL that the salaries of faculty nearing retirement are about twice those of newly hired faculty. Accordingly, prohibiting mandatory retirement might also exacerbate the financial problems colleges and universities are facing because of the reductions in public funds.

Those who oppose the exemption believe that there are not sufficient reasons to single out faculty for special, discriminatory treatment. They call it double discrimination—once on the basis of age and again on the basis of occupation—and argue that colleges and universities are using mandatory retirement to rid themselves of both undesirable and unproductive professors, instead of dealing directly with a problem that can afflict faculty members of any age. The use of performance appraisals, they argue, is a more reliable and fair method of ending ineffectual teaching service than age. Finally, they claim that there is no evidence that many professors would stay past 70 even if they could, and that predictions of dire consequences from uncapping the retirement age may be exaggerated. According to the Teachers Insurance Annuity Association and College Retirement Equities Fund, the average age at which faculty members begin collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

(C) STATE AND LOCAL PUBLIC SAFETY OFFICER PROVISIONS

As previously noted, the ADEA allows an exception against age discrimination in the workplace where "age is a bona fide occupational qualification (BFOQ) reasonably necessary to the normal operation of a particular business, or where the differentiation is based on reasonable factors other than age." The BFOQ defense has been most successful in cases that involve the public safety. In general, courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters because the safety of the public was at stake. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

An amendment added to H.R. 4154 in the House by a vote of 291 to 163, provided that public safety employees would be subject to the jurisdiction of States and local governments to determine whether or not they should be hired and whether or not they should be allowed to continue to work at any age. This amendment amounted, in effect, to a permanent exemption to the hiring and firing protections of the ADEA for police and firefighters. No other exemptions were contained in the House passed bill.

The Senate compromise allowed a temporary exemption for State and local public safety officers. This temporary exemption was approved by both the House and Senate and signed into law.

The exemption allows State and local governments to refuse to hire or to discharge law enforcement officers and firefighters based on their age if such persons had attained the age of hiring or retirement under a State or local law which was in effect on March 3, 1983 (immediately following the Supreme Court's decision in *EEOC* v. *Wyoming*), pursuant to a bona fide hiring or retirement plan. This provision is in effect for 7 years, until December 31, 1993. The legislation also requires the Secretary of Labor and the EEOC to conduct a study and to report to Congress on whether physical and mental fitness tests can be used as a valid measure to determine the competency of police officers and firefighters and to develop recommendations on standards that such tests should satisfy. The study is to be submitted to Congress within 4 year of enactment of the law. The law also requires that within 5 years of enactment, the EEOC propose guidelines for the administration and use of physical and mental fitness tests to measure the ability and competency of police and firefighters to perform their jobs.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, on March 2, 1983, in *EEOC* v. *Wyoming*, determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is a BEOQ for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress commerce powers—an argument not sustained by the Court.

In addition, in June 1985, the Supreme Court rendered two decisions in cases arising under the ADEA favorable to employees who had challenged the mandatory retirement policies of their employers. The first case, *Johnson* v. *Mayor and City Council of Baltimore*, Nos. 84-518 and 84-710 (June 18, 1985), involved six firefighters who challenged the City of Baltimore's municipal code provision that established a mandatory retirement age at 55 for firefighters. The Court of Appeals, accepting the city's argument, had held that the Federal civil service statute, which requires most Federal firefighters to retire at age 55, constituted a BFOQ for the position of firefighters employed by the city. The Supreme Court reversed this decision, stating that nothing in the *Wyoming* decision or the ADEA warrants the conclusion that a Federal rule, not found in the ADEA, and by its terms applicable only to Federal employees, necessarily authorizes a State or local government to maintain a mandatory retirement age as a matter of law. The Court found that it was Congress' indisputable intent to permit deviations from the mandate of the ADEA only in light of a particularized, factual showing. The Court concluded that Congress decision to retire certain Federal employees at an early age was not based on a BFOQ, but instead dealt with "idiosyncratic" problems of Federal employees in the Federal civil service. Accordingly, the Court ruled that a State or private employer cannot look to exemptions under Federal law as dispositive of BFOQ exemptions under the ADEA. There is a need, the Court said, to consider the actual tasks of the employees and the circumstances of employment to determine when to impose a mandatory retirement age.

The second case, *Western Airlines, Inc.* v. *Criswell*, No. 84-127 (June 18, 1985), raised a challenge under the ADEA to Western Airline's requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and copilot become incapacitated, were subject to mandatory retirement at age 60. The Supreme Court upheld a jury verdict for the plaintiffs against an airline defense that the age 60 requirement constituted a BFOQ. The Court confirmed that the BFOQ defense is available only if it is reasonably necessary to the normal operation or essence of a defendant's business. The Court also noted that an employer could establish this defense only by proving that substantially all persons over an age limit would be unable to perform safely and efficiently the duties of the job, or that it would be impossible or highly impractical to deal with older employees on an individualized basis.

In both of these cases, a unanimous Court seemed to be looking very critically upon attempts to expand the BFOQ defense beyond specific high-risk occupations. The Court also stressed the relationship between individual performance and employment in a particular task, rather than reliance on a standard of chronological age disqualification. Thus, by adopting a very narrow reading of the BFOQ exemption, the Court appears to have strongly endorsed individualized determinations.

Many States and localities have mandatory retirement age policies below age 70 for public safety officers and they were concerned about the impact these decisions will have. As of March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement or minimum hiring age laws. As a result, legislative proposals were made in Congress to exempt public safety officers from some or all of the ADEA provisions.

Supporters of such legislation argue that the mental and physical demands, and safety considerations for the public, the individual, and co-workers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Sponsors of the legislation believe that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA because of conflicting court decisions; and even if possible, would require costly and time consuming litigation. They note that jurisdictions wishing to retain the hiring and retirement standards that they established for public safety officers prior to the Wyoming decisions are forced to engage in costly medical studies to support their standards.

Supporters of an exemption question the feasibility of individual employee evaluations and some have cited the difficulty involved in administering the tests because of technological limitations concerning what human characteristics can be reliably evaluated, the equivocal nature of test results, and economic costs. They do not believe that individualized testing is a safe and reliable substitute for pre-established age limits for public safety officers.

Those who oppose an exemption believe that there is no justification for applying one standard to Federal public safety personnel and another to State and local public safety personnel. They believe that exempting State and local governments from the hiring and retirement provisions of the ADEA in their employment of public safety officers will give them the same flexibility that Congress granted Federal agencies which employ law enforcement officers and firefighters.

As an additional argument against exempting safety officers from the ADEA, opponents note that age affects each individual differently. They note that tests can be used to measure the effects of age on individuals, including tests that measure general fitness, cardiovascular condition, and reaction time. In addition, they cite research on the performance of older law enforcement officers and firefighters which supports the conclusion that job performance does not invariably decline with age and research shows that there are accurate and economical ways to test physical fitness and predict levels of performance for public safety occupations. All that the ADEA requires, they say, is that the employer make individualized assessments where it is possible and practical to do so. The only fair way to determine who is physically qualified to perform police and fire work is to test ability and fitness.

Last, those arguing against an exemption state that mandatory retirement and hiring age limits for public safety officers are repugnant to the letter and spirit of the ADEA, which was enacted to promote employment of older persons based on their ability rather than age and to prohibit arbitrary age discrimination in employment. They believe that it was Congress intention that age should not be used as the principal determinant of an individual's ability to perform a job, but that this determination, to the greatest extent feasible, should be made on an individual basis. Maximum hiring age limitations and mandatory retirement ages, they contend, are based on notions of age-based incapacity and would represent a significant step backward for older working Americans.

(D) PENSION ACCRUAL PROVISIONS

In May 1979 the Department of Labor (DOL) published an interpretive bulletin regarding the 1978 ADEA amendments. The DOL interpretation allowed employers with pension plans regulated under the Employee Retirement Income Security Act (ERISA) to cease pension contributions and pension credits for active employees who work beyond the normal retirement age specified in their pension and retirement plans. Specifically, these rules interpret the ADEA to permit pension plans to: (1) Cease employer contributions at "normal retirement age" (65 years of age under most plans); (2) cease credit of years of service, salary increases, and benefit improvements which occur after an employee reaches the normal retirement age specified in the plan; and (3) not adjust actuarially the benefits accrued as of normal retirement age for an employee who continues to work beyond that age (29 CFR 860.120).

Shortly after the publication of these interpretations, the administration and enforcement authority under the ADEA was transferred from DOL to the Equal Employment Opportunity Commission (EEOC). The EEOC subsequently commenced a review of the factors relevant to the DOL interpretation by requesting public comments on the continuation of present practices [48 Federal Register 41436 (September 15, 1983)]. Numerous groups and individuals responded to the request, providing the EEOC with hundreds of pages of information, most of which supported prohibiting employers from discontinuing pension benefit accruals at the normal retirement age. EEOC evaluated the public responses and, on June 26, 1984, voted to rescind the DOL opinion that accruals were not required and to replace it with a new proposal requiring continued contributions and crediting for workers past normal retirement age. Subsequently, in March 1985, the Commission unanimously approved proposed regulations requiring such accruals and allocations. However, EEOC never published the proposed regulations in the Federal Register.

Despite the Commission's unanimous vote to move forward with the change, a number of procedural processes, such as obtaining comments from other concerned Government agencies and approval by the Office of Management and Budget were still pending at the agency at the end of 1986. The failure of EEOC to act on its policy change prompted a public outcry and forced the hand of Congress.

Employers supported the old interpretation on the grounds that its reversal would cost them an exhorbitant amount of money. They argued that when ERISA was first enacted to regulate private pension plans, Congress intended that retirement plans not be required to recognize employment beyond normal retirement age either by accruing benefits or by actuarially adjusting existing benefits. Further, they suggested that the legislative history of the 1978 ADEA amendments confirmed that intent.

Proponents of continuing pension benefit accruals, on the other hand, argued that the old DOL/EEOC interpretations, insofar as they permit pension benefits to be frozen or suspended, have been contrary to the intent of Congress and to the ADEA's policy prohibiting employer discrimination based on age alone. They also argued that the absence of pension accruals is extremely costly to older employees, while providing employers with an undeserved windfall. Indeed, according to an October 1985 study by William M. Mercer-Meidinger, Inc., the total annual value of pension benefits lost because employers have not been granting full pension credit to those employees working beyond age 65 has been approximately $450 million. In addition, an October 1984 study by the Employee Benefit Research Institute found that an employee delaying retirement can lose up to half the value of benefits accrued at age 65.

On September 19, 1986, after lengthy debate, the Senate passed its version of the Budget Reconciliation Act, which included an amendment requiring continued pension benefit accruals for employees who continue to work beyond normal retirement age. Subsequently, House and Senate conferees agreed to a compromise provision which was approved by Congress on October 17, 1986, and eventually signed by the President (Public Law 99-509).

The provision prohibits any employee benefit plan from ceasing accruals or suspending plan contributions for an employee because of age. Employers are prohibited from excluding employees hired within 5 years of normal retirement age from participation under certain plans. The bill, however, does allow employers to discontinue accruals for employees who have reached a maximum benefit, a maximum number of years of service, or a maximum years of participation in the plan if these limits are "without regard to age." Employers are also allowed to offset actuarial increases against the accrual provision, as well as to establish a "floating" normal retirement age that could not be later than the fifth anniversary of the employee's participation in the plan. The effective date of this new provision is January 1, 1988.

The legislation represents a significant victory for the 150,000 to 200,000 employees 65 through 69 years of age whose benefit accruals were frozen at age 65. Passage of the pension accrual provisions provides older workers fair pension treatment and eliminates one more obstacle to the employment of older persons.

B. ISSUES

1. EARLY RETIREMENT

The rapid aging of the American population raises serious questions regarding early retirement from the work force. The demographic changes taking place in the United States, coupled with the continuing trend toward early retirement, characterize what some have characterized as the "early retirement timebomb."

According to the Bureau of Labor Statistics, the labor force participation of older men has been dropping dramatically for several decades. At the turn of the century, the majority of employees remained in the work force well into their seventies. In 1950, 46 percent of all men age 65 and over continued to work. This figure had dropped to 33 percent in 1960 and by 1986, a mere 16 percent were working.

This trend toward early retirement also extends into middle age. Since 1960, employment rates among men aged 55 to 64 have dropped by one-sixth, from 87 to nearly 67 percent. Three-quarters of all new Social Security beneficiaries each year retire well before their 65th birthday, and most now begin collecting benefits at age 63. A July 1985 General Accounting Office (GAO) study found that almost half of the individuals who receive private pensions start receiving them by age 62 and almost 60 percent start receiving them before reaching age 65. The increase in private pension receipt among persons under age 65 also reflects the trend toward earlier retirement. One study found that 67 percent of pension plan participants can retire with full benefits before age 65, up from 63 percent in 1983 and 1984.

This trend toward early retirement threatens to place serious strain on the economy. The first major reason for this strain involves the jeopardization of older Americans future economic security. Those who leave the work force are three times more likely to fall below the poverty level as those who remain. Second, earlier retirement contributes to the financial strain on Social Security and private pension plans. Third, serious shortages of skilled labor may develop in certain industries unless the early retirement trend is reversed. In contrast to these pressures to keep older persons in the labor force, however, it appears that current labor demand is not sufficient to satisfy older persons' employment needs. Therefore, the conflict between early retirement and the need to reverse the decline in labor force participation rates has become a major public policy dilemma. A breakdown of older worker employment by occupation is provided in table 1.

TABLE 1.—OLDER WORKER EMPLOYMENT BY OCCUPATION

[Numbers in thousands]

	Total [1]	Percent	55–59	Percent	60–64	Percent	65+	Percent
Managerial and professional specialty	27,742	(25)	1,860	(27)	1,162	(26)	727	(24)
Technical/sales and administrative support	35,082	(31)	2,018	(29)	1,355	(30)	894	(29)

TABLE 1.—OLDER WORKER EMPLOYMENT BY OCCUPATION—Continued

[Numbers in thousands]

	Total [1]	Percent	55–59	Percent	60–64	Percent	65+	Percent
Service	15,054	(13)	871	(13)	631	(14)	570	(19)
Precision production craft and repair	13,569	(12)	893	(13)	502	(11)	242	(08)
Operators, fabricators and laborers	17,486	(16)	1,059	(15)	626	(14)	290	(10)
Farming, forestry and fishing	3,507	(03)	248	(04)	238	(05)	318	(10)
Total	112,440	(100)	6,949	[2] (100)	4,515	(100)	3,041	(100)

[1] Total is for total U.S. population aged 16+.

[2] Does not equal 100 percent due to rounding.

Annual Figures for 1987 derived from the current population survey—Bureau of Labor Statistics.

According to Dr. James H. Schulz of Brandeis University, unlike many people believe, the aging of the American workforce, in of itself, is not a major problem. Rather, the fact that the age at which people leave the work force has been decreasing is a ticking timebomb. In the past, it was common practice to actuarially reduce the benefits paid to early retirees to account for the increased cost associated with paying out the benefits over a longer period of time. During the past decade, however, an increasing number of employers have chosen to absorb those added costs themselves, in order to encourage early retirement. According to Dr. Schulz, the economic costs of a pension for a worker retiring at age 60 are twice those for a worker leaving the workforce at age 65.

2. ADEA ENFORCEMENT PROCEDURES

Although certain substantive sections of the ADEA were taken from title VII of the Civil Rights Act of 1964, in passing the act, Congress was careful to incorporate into section 7 of the ADEA, the higher level of protection afforded by the Fair Labor Standards Act of 1938 (FLSA). According to the report on the original ADEA legislation (House Report 90–805), "The investigation and enforcement provisions of the bill essentially follow those of the FLSA. The enforcement provisions replace those in the original bill which were similar to the National Labor Relations Act approach. The former authorizes the employee, as well as the Secretary of Labor, to seek remedies through court action."

The Supreme Court noted the incorporation of FLSA enforcement procedures into the ADEA in its decision in *Lorillard* v. *Pons* [434 U.S. 575 (1978)]. In this civil action, the plaintiff sought lost wages and demanded a jury trial. The plaintiff contended that the ADEA's structure demonstrated congressional intent to provide for such a right.

In *Lorillard,* the Court concluded that the incorporation of the FLSA scheme into section 7 of the ADEA indicated congressional intent to bestow the right of trial by jury. According to the Court, ". . . we cannot assume, in the face of Congress' extensive knowledge of the operation of the FLSA, illustrated by its selective incorporation and amendment of the FLSA provisions for the ADEA, that Congress was unaware that courts had uniformly afforded jury trials under the FLSA." The *Lorillard* holding was codified in

1978 when section 7(c) of the ADEA was amended to provide expressly for jury trials in actions brought under that section.

Among the other FLSA provisions incorporated into the ADEA are those entitling a prevailing plaintiff to liquidated damages where the employer has willfully violated the act. No punitive damages or damages for pain and suffering are recoverable under the ADEA. A plaintiff is limited to damages measured by lost earnings and an additional equal amount as liquidated damages where applicable. Thus, liquidated damages operate, in effect, as a substantive for punitive damages.

While judges have the authority to return a victim of age discrimination to the position he or she may have lost due to unlawful discrimination, it is often inappropriate or impossible to do so. The job may no longer exist or it may be unavailable. In addition, a high degree of animosity, hostility, or antagonism may exist between the employer and employee, making a productive working relationship impossible. Reinstatement may also be inappropiate where it would require displacing another person from the plaintiff's former job.

The importance of liquidated damages lies in the fact that judges are often reluctant to order job reinstatement or monetary awards beyond the date of the decision, even though the plaintiff may continue to experience problems securing appropriate employment. In addition, the legislative history indicates that the ADEA imposes double damages to provide an effective deterrent to willful violations. Liquidated damages help defer future violations by encouraging employers to adhere to the proscriptions of the Act, just as jury trials provide an important incentive for voluntary compliance.

While Congress incorporated certain FLSA enforcement procedures into the ADEA, it also incorporated provisions which are not included in the FLSA. The ADEA, unlike the FLSA, specifically requires that the EEOC undertake informal methods of conciliation, conference, and persuasion in an attempt to effect voluntary compliance before instituting legal action.

3. WAIVERS OF RIGHTS

In *Lorillard*, the Court stated that, "[the] selectivity that Congress exhibited in incorporating provisions and in modifying certain FLSA practices strongly suggests that but for those changes Congress expressly made, it intended to incorporate fully the remedies and procedures of the FLSA." In addition, the Court held that not only the FLSA enforcement provisions, but also the pre-ADEA case law dealing with enforcement of FLSA rights, were incorporated into the ADEA's section 7 enforcement provision.

Under the pre-ADEA case-law dealing with contractual waivers of private rights under the FLSA, there were two Supreme Court cases which, taken together, may be interpreted to hold that FLSA rights cannot be privately waived [see Brooklyn Savings *Bank* v. *O'Neil*, 324 U.S. 967 (1945), and *Schultz, Inc.* v. *Gangi*. 328 U.S. 108 (1946)]. It would follow, then, that under the ADEA enforcement scheme nonsupervised private agreements to waive ADEA rights would also be impermissible.

In *Runyan* v. *National Cash Register Corp.* [787 F.2d 1039 (6th Cir. 1986)], however, a private release form purporting to waive all claims against an employer was held by the U.S. Court of Appeals to be binding under the ADEA. By a vote of 11 to 2, the Court rejected the argument that an unsupervised private release of rights under ADEA is void as a matter of law. The Court's holding was limited to the circumstances of the case where nothing indicated that the employer had exploited its superior bargaining power by forcing the employee to accept an unfair settlement.

Those who believe that unsupervised waivers of rights are, in fact, not permitted under the ADEA have been highly critical of the *Runyan* decision's overall applicability to the ADEA. The plaintiff in the case was an experienced labor attorney and, therefore, extremely knowledgeable of the law. This has prompted many to argue that *Runyan* is more the exception than the rule. Indeed, according to a 1981 Louis Harris survey conducted for the National Council on Aging, over half the workers age 40 to 70 (those protected by the ADEA as of 1981) are unaware of the protections afforded them under the ADEA. Waiver opponents argue that, given this fact, it would be extremely difficult for most workers to execute knowing and voluntary waivers.

In the past, the EEOC recognized that application of the FLSA enforcement provisions to the ADEA may be interpreted to mean that individuals may not waive their rights or release potential liability even if the action is voluntary and knowing, except under EEOC supervision. On October 7, 1985, however, EEOC published in the Federal Register a Notice of Proposed Rulemaking (NPRM). This proposed administrative exemption and legislative regulation allowed for non-EEOC supervised waivers and releases of private rights under the ADEA. Nearly 2 years later on July 30, 1987, the EEOC approved a final rule which permits unsupervised waivers.

The exemption allows employers and employees to issue private agreements which contain waivers and/or releases of private rights under the ADEA without the supervision or approval of the EEOC. The Commission argues that the remedial purposes of the act will be better served by allowing agreements to resolve claims whenever employees and employers perceive them to serve their mutual interests, provided such waivers of rights are knowing and voluntary. To this view the Commission cites the similarities between the ADEA and title VII of the Civil Rights Act of 1964 and notes that under title VII, such unsupervised waivers of private rights are permissible. However, in *Lorillard,* while the Court acknowledged that many of the ADEA's prohibitions were derived *in haec verba* from title VII, it found significant differences in the remedial and procedural provisions of the two laws. The Court stated that "rather than adopting the procedures of title VII for ADEA actions, Congress rejected that course in favor of incorporating the FLSA procedures even while adopting title VII's substantive prohibitions . . . [The] petitioner's reliance on title VII, therefore, is misplaced."

In justifying its regulation, the EEOC heavily relies upon the *Runyan* case. Opponents of the rule, however, note the limited scope of the *Runyan* decision and argue that such a narrow decision does not justify the EEOC's decision to grant blanket waivers of individuals' ADEA rights without Government supervision. Waiver opponents also cite the filing of a strong dissent in the case and note that EEOC's proposed regulation is cited in the final *Runyan* decision. Therefore, they argue, EEOC's heavy reliance on the Court's ruling is somewhat misplaced.

EEOC's regulation validating unsupervised waivers represents a significant change in current law and practice. Because they believe the new rule is contrary to the ADEA and could threaten older worker's basic rights and protections, many Members of Congress have expressed grave reservations about its advisability.

Opponents of the exemption say that it is overly broad in that it applies not just to certain employers or employees in certain exceptional circumstances, but rather to any and all employers under every conceivable circumstance. The public interest served by the proposed regulation would have to be considerable in order to justify the breadth of this proposed exemption. Opponents argue, however, that the only public interest rationale offered by the EEOC is that the exemption will promote the expeditious resolution of disputes. It is not clear how the broad exemption would provide for more expeditious resolution of disputes, and if it does promote that goal, whether that interest would outweigh possible abuses of the exemption. They note that the EEOC discussion does not set forth any factual information which justifies changing current law. In addition, they note that the Commission has received only a handful of requests for supervision in its history (numbers cited are inconsistent, but range from 1 to 7) and that waivers have added little, if anything, to the Commission's administrative responsibilities.

Additionally, the language of the proposed regulation does not limit itself to waivers or releases stemming from employment disputes between employer and employee or job applicant. Conceivably, an employer could ask a job applicant to agree that if the applicant were hired, that he or she would retire at a given age. Finally, opponents say that simple reliance upon title VII rather than the FLSA will only serve to complicate and prolong ADEA litigation since the context of ADEA waivers is very different from that under title VII. They contend that in many situations, it may be difficult to ascertain the state of mind of an employee when he or she agrees to waive statutory rights under the ADEA. To ensure that an employee's rights are protected, a waiver must be supervised by an objective entity such as the EEOC or a court of law. Only then can one be reasonably assured that a waiver has been knowing and voluntary.

4. Apprenticeship Programs

According to EEOC's current interpretation, apprenticeship programs are exempt from the proscriptions of the ADEA. This exemption, in effect, permits employers and labor unions to exclude men and women over age 40 from entering these programs solely because of their age.

The current interpretation has been in effect ever since 1969, when the Department of Labor published interpretive guidelines which provided that apprenticeship programs are not subject to the requirements of the ADEA. Since then, the Labor Department has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector since they are widely seen as a training program for youth in which the initial investment and training can be recouped over the apprentice's worklife. However, others contend that to exclude older workers from participation in bona fide apprenticeship programs is to deny them needed retraining opportunities. They argue that rapid technological changes often make the skills of older workers obsolete.

Upon receiving responsibility for upholding the ADEA in 1979, the EEOC began to explore the possibility of amending the old Labor Department interpretation, however, attempts to do so were unsuccessful. Subsequently, a 1983 decision in *Quinn* v. *New York State Electric & Gas Corporation,* 569 F. Supp. 655 (1983), held that neither the language of the ADEA nor its legislative history support a conclusion that Congress intended to exempt apprenticeship programs from the ADEA. Following this decision, the EEOC decided to reconsider the exemption and, on June 13, 1984, unanimously voted to rescind the current exemption and issued proposed regulations which would prohibit arbitrary age discrimination in such programs. The regulations, however, languished before the Office of Management and Budget, apparently because the Department of Labor has opposed the proposed change.

Finally, on July 30, 1987, the Commission reversed itself and voted against changing the old interpretation. According to EEOC Chairman Clarence Thomas, any decision to change that position would be "properly left for the Congress." This was the same day the Commission cited its broad authority to promulgate regulations in passing its rule (discussed above) permitting employees to waive their ADEA rights without EEOC supervision. By retaining the old Labor Department interpretation, EEOC has effectively precluded midlife and older workers seeking critical new jobs skills from receiving needed training through these programs.

5. Health Costs

While we have witnessed a steady decline in labor force participation by older people over the past several decades, concerted efforts are now being directed toward reversing this trend. "Worklife extension" is the term used to describe the move to extend the worklife of older persons willing and able to work. An important theme in the discussions of worklife extension is the health of the older population. Employers and policymakers are concerned about the health implications of extended worklife, especially as they relate to issues of labor supply, productivity, employee health costs, and health maintenance.

A February 1985 information paper entitled "Health and Extended Worklife," prepared for use by the Special Committee on Aging, presents information about the health status of older persons as it may relate to extended worklives. The findings of the study indicate that the noninstitutionalized older population, and particularly the younger members of that population, are healthier than is widely believed. Health is one of several variables which affects supply of workers, their level of productivity, and their utilization of health services and the new data presented in the paper will assist the Congress and employers in making informed decisions about employment and retirement issues.

Conventional wisdom suggests that older workers are paid more than younger workers for the same job and that, therefore, older workers are more expensive. This rationale has frequently been used to support early retirement programs on the assumption that younger workers can be hired at lower cost to replace older workers. There is, unfortunately, a dearth of empirical information to help discern whether it costs more to employ older workers than younger workers. In September 1984, the Special Committee on Aging released an information paper which examined factors related to patterns of labor costs by age, and disucsses direct compensation, employee benefits, turnover, training, performance, and productivity.

The evidence indicates that there are some types of employment costs which vary by age, and that overall compensation costs increase by age, largely because of increasing employee benefit costs. There is, however, no statistical evidence that direct salary costs on an economywide basis increase by age. Employee benefit costs are not usualy separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs, combined with an expanding set of laws and regulations, have served, however, to focus the spotlight on employee benefit costs for older workers, and it is possible that employers will give more consideration to this issue in the future.

The belief that older workers cost more seems generally related to feelings about performance and productivity. There is no statistical evidence to indicate generally poorer performance or productivity by age, and the limited data available refutes the basic notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work changes and the skills of the employee are not kept up to date, there will be an increasing mismatch of skills to the job, leading to deterioration of performance on that specific job. If older workers are to be cost-effective, their skills must be continuously updated through training and education to assure continued productivity. The two major conclusions of the information paper are:

> It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills to compete on a fair basis for jobs within or outside of their companies. Up-to-date skills are more important than any age-related capabilities in human resource cost and older worker productivity.
>
> Legislative and regulatory requirements affecting employment costs for older workers should not place undue cost or administrative problems on employers. Such requirements can discourage the employment of older workers.

A 1986 report by the American Association of Retired Persons entitled, "Workers Over 50: Old Myths, New Realities," found that 62 percent of responding firms found that the extra cost of health insurance for employees age 50 and over to be insignificant compared with total company health care costs. Only 16 percent of the employers rated a 55-year-old employee as being extremely costly to insure, as compared to 34 percent of firms which rated a 30-year-old with two dependents very expensive to insure.

Employer's concerns about the rising cost of providing health insurance for older workers, however, has been worsened by recent legislative action. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising costs of Medicare by shifting costs to private payors. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), legislated changes in Medicare coverage for older workers. As of January 1983, employers could no longer advise workers that they were to be dropped from company group health insurance plans at age 65 because they were eligible for Medicare. TEFRA requires that company plans bear the primary insurance costs of illness, while Medicare becomes secondary. The TEFRA requirement raised employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any of its employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69—about 37 percent of all private sector workers in this age group—will be affected by these changes, at a total cost to employers of about $500 million. About 286,000, or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. In addition, about 148,000 workers who were previously excluded from coverage are likely to be covered by employer plans. The health plan costs of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concludes that these changes may initially reduce the demand for workers of this age by about 1 percent.

Two major provisions in the Deficit Reduction Act of 1984 (DEFRA) also have some effect on the costs of employing older workers and on the costs to older workers remaining employed longer. The first is section 2301 of DEFRA, which modified the working aged provision—originally included in TEFRA—such that employers must offer group health coverage to an employee who has not reached age 65, if the employee has a spouse age 65 through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer coverage that is the same as that offered to emloyees with spouses under age 65. In such cases, Medicare would be the secondary payer, while the employer-sponsored plan would be primary. The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors they are significant. Now employers have yet another reason not to hire or retain older workers—those under age 65—because if they have an older spouse, the employer, rather than Medicare, is required to pay the health costs for the spouse. These added costs may encourage employers to steer clear of older workers.

The second provision, section 2338 of DEFRA, removed a disincentive to older workers remaining on their employer's health plan. Under the TEFRA provision, those employees who elected, after age 65, to remain in the employer health plan would have been penalized for not enrolling in part B of Medicare upon their 65th birthday. This penalty amounted to a 10-percent increase on annual premiums for each 12 months that the employee does not enroll after his or her 65th birthday. Since the Medicare coverage was duplicative of the employer plan there was no need to enroll in part B until after retirement—except for the stiff penalty imposed. DEFRA waived the part B premium for workers and their spouses aged 65 through 69 who elect private coverage under the provisions of TEFRA. It also established special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

Finally, employers health care insurance obligations to older employees under the ADEA were expanded by the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-272) signed by the President on April 7, 1986. The law removed the upper age limit of 69 and employers will now be required to offer employees and their spouses aged 69 and over the same group health insurance coverage provided to younger workers.

Another issue is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. Indeed, in 1983 the Wall Street Journal reported that insurance companies know that groups containing older people will run up bigger medical bills than those with younger participants. As a result, insurance premiums for the group plans have soared and some insurance companies have gotten out of the small-group business altogether because they concluded these plans were unprofitable. Higher insurance premiums for veteran employers create another disincentive for those employers to hire and retain older workers.

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable example of this are the 1983 amendments to the Social Security Act. The compromises that resulted in the amendments (Public Law 98-21) reflect the belief in Congress that older people are healthier today and therefore, can continue to work longer. The desired effect of the amendments is that older workers will be discouraged from leaving the labor force by an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

6. PERSONNEL PRACTICES FOR AN AGING WORK FORCE

One of the most important issues before the Congress today is the need to expand employment opportunities for those older men and women who want to work full or part time. Substantial numbers of retired people both need additional income through employment and would like to do productive work, rather than retire full time. However, many of these retirees depend upon the availability of more appropriate and flexible employment opportunities, and the removal of existing financial disincentives. The Bureau of National Affairs reported 1986 survey results which showed that only 6 percent of responding employers had a policy of encouraging older workers to stay on the job and just 2 percent of the firms provided retraining specifically for the older employee.

A major problem in the proliferation of innovation among business leaders with regard to older worker policies is the absence of information about models that have been tried in the private sector. Examples of new personnel policies and innovative work options to accomodate the unique needs of older workers are given in a February 1985 information paper, "Personnel Practices for an Aging Work Force: Private Sector Examples," prepared for use by the Special Committee on Aging. The information paper fills an important information gap by providing employers, policymakers, and the general public with descriptions of successful employment practices designed to capitalize on the contributions of older workers.

A relatively recent development has been the use of early retirement options, with enhanced benefits for senior employees. Many employers, faced with having to tighten their belts and reduce the size of their workforce, have begun offering their older employees (with high salaries), financial incentives to leave the workplace. In 1986, for example, three major companies (Du Pont, IBM, and Xerox) announced early retirement incentives to trim their work forces.

As the use of exit incentives have risen, so have questions about their discriminatory effect. The ADEA states that certain exit incentive programs can include provisions which would otherwise be considered discriminatory, but only if they are not used as a subterfuge to evade the purposes of the ADEA. This has been interpreted to permit differential benefits, but only where justified by the increased cost of providing benefits to older workers. At this time, there are divergent circuit court rulings on the cases testing the legality of exit incentives. While it is too soon to understand all of the implications of this new trend, economists have expressed concern at the loss of so many productive workers. The use of early retirement incentives is of growing interest to older worker advocates, as well as to employers, and the issue will assuredly continue to be closely monitored by watchdog interest groups.

C. RESPONSES

1. Hearings

On September 10, 1987, the Senate Special Committee on Aging held a hearing examining the Equal Employment Opportunity Commission's effectiveness in carrying out its obligations under the Age Discrimination in Employment Act. Senator Melcher called the hearing because of concerns that EEOC enforcement and administration of the ADEA has been inadequate.

During the hearing, the committee heard testimony on several subjects, including EEOC litigation, charge processing, rulemaking, and staffing. Critics charged that the Commission often allows cases to languish for months, even years at a time, without taking any substantive action, and that many EEOC staff have lost or misplaced charges which have been filed. Concerns were also raised regarding the number of complaints receiving some type of settlement after a charge was filed with the Commission. While in 1980 approximately 32 percent of all cases filed with EEOC were settled, this number had declined to 12.5 percent by 1986.

Some argued that the Commission has not only been lackadaisical in its protection of older workers, but has actually taken steps that diminish their rights. Charges were made regarding the Commission's delay in issuing regulations requiring continued pension accrual for those working beyond normal retirement age, its decision to condone early retirement and exit incentive programs which offer decreased awards to older workers and it decision to allow unsupervised waivers of ADEA rights. The Commission was also criticized for shifting its litigation emphasis away from systemic discrimination to cases involving individual complaints. Critics charged that by failing to pursue large scale age discrimination cases involving an employer's scheme of hiring, EEOC has chosen to attack age discrimination in an ad hoc fashion. Statistics were also cited which show that of all ADEA charges filed with the agency, fewer than 1 percent are even recommended for litigation.

In response, the Commission argued that its ADEA enforcement performance has been improving. EEOC cited an increased litigation caseload, an investigative compliance policy designed to enable EEOC to deal more effectively with uncooperative respondents in Commission investigations and an increase in monetary relief recovered by the EEOC through litigation to show that they have been effectively enforcing the ADEA. EEOC testified that while $2.3 million went to victims of age discrimination in 1980, in 1986 the Commission recovered $36.6 million through ADEA litigation. Critics, however, contend that monetary relief is misleading. They claim that it is the number of persons helped, not the amount of money recovered, that is important.

2. LEGISLATION

(A) WAIVERS OF RIGHTS

Concern exists regarding EEOC's recently finalized rule permitting unsupervised waivers of employee rights under the ADEA. Because of these concerns, the Senate passed an amendment offered by Senator Melcher to the Commerce, State, Justice appropriations bill which suspends the rule during fiscal year 1988 (Public Law 100-202). The amendment also provides that no funds may be obligated or expended by the Commission to give effect to any policy or practice pertaining to unsupervised waivers under the Age Discrimination in Employment Act.

Many in Congress, as well as a variety of organizations, have expressed concerns that EEOC's new regulation reverses long-standing policy with respect to the ADEA. In offering the amendment, Senators Melcher and Metzenbaum argued that because the enforcement mechanism of the ADEA was fashioned, in large part, using Fair Labor Standards Act (FLSA) procedures, EEOC's regulation is contrary to the intent and purpose of the ADEA. Section 16(c) of the FLSA requires that any waiver must be supervised. The EEOC justifies the new rule by claiming it is consistent with the enforcement procedures of title VII of the Civil Rights Act of 1964, which permit unsupervised waivers.

In addition to rejecting EEOC's title VII arguments, critics of the regulation contend that because permitting unsupervised waivers contravenes both FLSA and ADEA enforcement procedures, the Commission has overstepped its prerogatives by issuing its rule. They argue that the Commission's authority to issue legislative regulations under the ADEA is limited to rules consistent with the language and purpose of the statute. Rules contradicting the statute's provisions are, therefore, beyond the EEOC's authority.

EEOC has argued that a conflict exists within the ADEA because the framers of the ADEA sought to insure the expeditious resolution of disputes due to their concern that delays could prejudice the claims of older workers. According to the Commission, "requiring government supervision of releases and waivers is at odds with this Congressional goal." According to the American Association of Retired Persons, however, no such conflict exists. AARP has filed a "Petition for Reconsideration and Repeal" of the new regulation, in which they argue that most circumstances involving a waiver do not involve disputes and therefore do not require speedy resolution. Indeed, in situations where an employee is asked to sign a waiver in exchange for accepting a package of early retirement benefits, speed can work to his or her detriment. Employees often feel forced into a rapid decision to accept or forego a questionable retirement benefit. This pressure can color a worker's decision regarding whether or not to enter into a waiver agreement, and is why Congress chose to incorporate Fair Labor Standards Act procedures prohibiting unsupervised waivers into the ADEA.

The ADEA and title VII differ in another important aspect; the ADEA requires that EEOC engage in conciliation efforts during a dispute, while title VII does not. Therefore, the Commission will normally be actively involved in conciliation or other proceedings when a waiver is requested during a dispute. This fact greatly weakens the EEOC's argument for the necessity to encourage quick dispute resolution.

Finally, the ADEA does not require that all waivers be supervised by the EEOC, but simply does not recognize unsupervised waivers as valid. Senator Melcher's amendment is a restatement of that law.

(B) AGE DISCRIMINATION AWARENESS

Age discrimination continues to pervade the American workplace. While many industries recognize the value of hiring experienced older workers, others continue in their attempts to subvert the law. In addition, not only do many older workers fail to realize when they are being discriminated against, but many do not understand their rights and protections under the Age Discrimination in Employment Act. According to a 1981 Louis Harris survey, approximately half of the older workers polled were unaware of their ADEA rights and protections. Given the fact that no concerted awareness campaign has taken place since that time, these statistics are unlikely to have improved.

In response to this lack of awareness, Senator Melcher amended title V of the Older Americans Act to require the Department of Labor to furnish title V contractors with printed materials regarding age discrimination in employment. The contractors will, in turn, distribute this information to program participants to apprise them of their lawful rights.

The Senior Community Service Employment Program under title V of the Older Americans Act provides many seniors with needed jobs and income. Title V is the most visible federally supported employment program and is one of the few remaining job creation programs. For this reason, supporters of the amendment believe that title V contractors will provide an excellent vehicle for increasing awareness.

(C) OLDER LABOR FORCE RE-ENTRANTS

In recent years, there has been an increasing trend toward early retirement from the work force. The average age at which people begin to draw Social Security benefits is now 63. However, there is growing concern in some circles about the consequences of early retirement. Many contend that a large number of employees who leave the work force, either voluntarily or due to forced retirement, find themselves ill-prepared for the financial consequences. While many believe that retirees who left the work force at too early an age are attempting to return, there is presently little proof.

On October 14, 1987, Senator Melcher offered an amendment to the Labor, HHS, Education appropriations bill which requires a study of older persons who are attempting to re-enter the work force. A version of this amendment was subsequently added to H.J. Res. 395, which was signed into law on December 22, 1987 (Public Law 100-202). The amendment requires the Secretary of Labor to prepare and submit a report to Congress not later than 1 year after enactment. Senator Melcher argued that formulation of an informed policy of retraining and job placement will depend upon an understanding of older workers' income and retraining needs, their employment interests, and the requirements of their potential employers.

Senator Melcher also expressed concern regarding midlife and older women's ability to enter the job market. Many of these women, some of whom have never held a job, are presently attempting the difficult task of entering the job market. Many other women, who originally left the work force to raise a family, are also attempting to find employment. More must be known regarding the marketability of these women's skills for the jobs they are attempting to find, as well as the income available to them.

For the purposes of the report, Senator Melcher submitted a list of topics for study, which included:

(1) The number of workers who have previously retired or been pressured to leave a job and are reentering the work

force, together with their reasons for desiring to reenter the work force;

(2) The reasons for such older workers retiring or being pressured to leave their previous job,

(3) The period of time an average sample of such older workers were not in the work force after retirement prior to reentering the work force;

(4) The period of time that an average sample of such older workers attempting to reenter the work force took before finding a new job;

(5) The number of such older workers who attempt to reenter the work force but who cannot;

(6) A description of the occupations which older workers who are attempting to reenter the work force were engaged in prior to retiring or being pressured to leave the work force;

(7) The salary levels and benefit levels such older workers receive upon reentering the work force, as compared with the salary and benefit levels they had received prior to leaving the work force;

(8) A description of the kinds of employers who hire such older workers;

(9) The numbers of older workers who are being hired for part-time new jobs, full-time jobs, job sharing arrangements, and flex-time arrangements;

(10) The educational and training level acquired by such older workers prior to their retirement and its effect upon their ability to reenter the work force; and

(11) The number of such older workers who are women either entering the work force for the first time or reentering after having left the work force to raise a family, along with their previous work experience and training. It was also suggested that the Department of Labor define "older worker" as an individual who has attained at least 40 years of age, since such a worker would fall under the purview of the ADEA.

3. RULEMAKING AND NOMINATIONS

(A) PENSION ACCRURAL

As previously mentioned, an amendment to the Omnibus Budget Reconciliation Act of 1986 (OBRA) required that the EEOC, Internal Revenue Service (IRS), and Department of Labor issue regulations which require continued contributions, allocations, and accruals under employee pension plans regardless of an employee's age. OBRA mandated that the three agencies consult one another to achieve consistency in their regulations. The regulations are to cover plan participants who perform at least one hour of service in a plan year beginning on or after January 1, 1988.

On November 27, 1987, the EEOC issued its proposed rules regarding continued accruals in employee pension benefit plans (52 Federal Register 45360). However, EEOC's proposed regulations sparked the immediate concern of a variety of organizations as well as Members of Congress. Because of their misgivings about the proposed rule's inadequacies, Senators Melcher, Kennedy, Metzenbaum, and Grassley, along with Representatives Pepper, Roybal, Hawkins, and others, submitted joint comments to the EEOC. Those comments discussed congressional reservations regarding the Commission's apparent lack of coordination with the IRS in formulating its proposed regulations, as well as concern that the proposed regulations are inconsistent with the mandates of OBRA.

The Commission's proposed regulations state that pension benefit accrual does not extend "to an employee for any plan year beginning before January 1, 1988, even if the employee is credited with at least 1 hour of service in a plan year beginning on or after January 1, 1988." Members of Congress, on the other hand, assert that OBRA requires continued benefit accruals for employees who work past normal retirement age, but does not exclude years of service completed in plan years beginning before January 1, 1988. OBRA requires that the Department of Labor, Department of the Treasury, and the EEOC issue consistent regulations by February 1, 1988.

(B) NOMINATIONS TO KEY EEOC POSITIONS

Nominations to EEOC positions in 1987 received little attention when compared to 1986. While the highly controversial nomination of Jeffrey I. Zuckerman to the position of EEOC General Counsel was rejected in May 1986, nearly a year later, Charles A. Shanor's nomination to that same position was met with little opposition. Mr. Shanor, a professor of law from Emory University, was confirmed by the Senate on March 27, 1987.

In other action, two vacancies were filled on the Commission itself. On June 25, 1987, Evan J. Kemp, Jr., was sworn in as Commissioner. Previously, Mr. Kemp was Executive Director of the Disability Rights Center, as well as a lecturer at the Law School of Catholic University. Subsequent to Commissioner Kemp's confirmation, Joy Cherian was named to fill the final vacancy on the Commission. He was sworn in on November 5, 1987, thus providing the EEOC with its full complement of five Commissioners. Commissioner Cherian was employed by the American Council of Life Insurance in various capacities from 1973 until his 1987 appointment to the Commission.

As of January 1, 1988, the five members of the Equal Employment Opportunity Commission included Chairman Clarence Thomas, Vice Chairman R. Gaull Silberman, Commissioner Tony Gallegos, Commissioner Evan J. Kemp, Jr., and Commissioner Joy Cherian.

D. PROGNOSIS

A variety of issues must be resolved in the years to come with respect to the employment of older and midlife workers. These include not only mandatory retirement for tenured university faculty, public safety officers, and certain other professions, but also the clear necessity for increased protection against the injustice of age discrimination. Congress' decision in 1986 to eliminate mandatory retirement for most professions is evidence of the growing national commitment the employment of older workers. The 1986 amendments also acknowledged that age does not necessarily determine an individual's functional ability. While stereotypes abound about regarding unproductive, fractious older employees, there is a growing realization that older workers are a very diverse group.

While positive steps have been taken in recent years to guarantee the rights of older workers, the positions, intent, and language of the ADEA need further clarification. Controversy remains regarding apprenticeship programs and waivers of employees ADEA rights. In addition, while the 99th Congress intended that the pension accrual amendments to OBRA clarify the law in this regard, EEOC's proposed regulations threaten to feed the dispute. This confusion impedes the effectiveness of the ADEA and must be eliminated. Resolution of these disputes will become even more crucial as the American work force continues to age.

The phenomenon of an aging work force presents a variety of potential problems, especially when considered in tandem with the clear trend toward early retirement. In attempting to downsize their work force, many companies have chosen to absorb the cost of offering early retirement packages to their employees. However, there is growing concern that in so doing, many companies merely consider short-term savings rather than long-term costs such as lost experience, increased pension liabilities, and increased training costs. In the future, these factors promise to play an increasing role in the American labor market.

As the Nation's population ages, there will be additional pressures to maintain a larger elderly work force. This will likely result in the eventual conclusion by business interests that it is to their advantage to modify their current employment practices and provide incentives for older workers to remain on the job. As this occurs, there may well be less of a need for Federal intervention to assure that older Americans are not victimized by age discrimination. However, until the advantages of employing and retaining older workers are widely acknowledged by business, it will remain essential that older persons who desire to work can rely on the EEOC to protect their ADEA rights.

In the near term, therefore, close oversight by the Congress—and particularly the Senate Special Committee on Aging—over the EEOC's enforcement and administration of the ADEA will be an important priority. In the long term, if for no reason other than economic necessity, attitudes about and treatment of elderly workers are likely to improve. However, while we anxiously await the development of these positive changes, the protection of older American workers from the degradation and injustice of age discrimination remains essential.

Chapter 6

SUPPLEMENTAL SECURITY INCOME

OVERVIEW

In recent years the Supplemental Security Income (SSI) Program has escaped budget cutting efforts directed at other means-tested programs. However, it is unclear how long the program will remain under protected status in the face of the enormous budgetary pressures that will continue to be generated in future years.

Two proposals were the basis for major legislative efforts to enact SSI changes during 1987: H.R. 2795, introduced by Representative Matsui of California on June 26, 1987, and S. 1635, introduced by Senator Pryor and Chairman Melcher of the Special Committee on Aging on August 7, 1987. Although these bills were not identical, they shared many of the same provisions and significant portions of both bills were incorporated as part of the budget reconciliation legislation.

A. BACKGROUND

The Supplemental Security Income (SSI) Program provides a guaranteed minimum income to the Nation's aged, blind, and disabled. Enacted in 1972 as title XVI of the Social Security Act, SSI was designed to establish a uniform, national income floor to ensure the economic security of America's most needy and vulnerable groups. Over 4.3 million people receive benefits from SSI, with maximum Federal monthly benefits in 1987 amounting to $340 for individuals and $510 for couples. SSI is financed through general revenues, and is administered by the Social Security Administration (SSA).

SSI was created to consolidate at the Federal level three State administered public assistance programs: Old-age assistance (OAA), aid to the blind (AB), and aid to the permanently and totally disabled (APTD). Congress intended that federal financing and administration would:

(1) Simplify administration of welfare and provide fiscal relief to the States;

(2) Provide more adequate, more uniform, and more equitable benefits;

(3) Reduce the stigma of welfare by making payments through SSA and thereby associating SSI with social insurance;

(4) Improve incentives for the poor to seek employment; and

(5) Decrease harassment of recipients by eliminating obstructive eligibility investigations to determine need, and doing away with lien and relative responsibility laws.

After over a decade of program operation, the basic structure and purpose of SSI has not changed in any substantial way. Legislation addressing SSI has primarily focused on improving administrative efficiency, increasing intraprogram equity, and protecting former recipients of the State programs from losing benefits due to federalization.

To qualify for SSI, an individual must be 65 or over, blind or disabled, and demonstrate need for income supplementation. Need is determined through a means test which is an evaluation of income and assets in relation to established maximum standards. In 1987, recipients' unearned income (Social Security and other benefits) could not exceed by more than $20 the maximum Federal SSI benefit ($340 for individuals, $510 for couples). However, in calculating assets, the value of a person's home is not counted, nor is the first $4,500 in fair market value for an automobile and the first $2,000 in equity value for household goods and personal effects. Regulations also provide guidelines for determining the countable value of certain other assets, such as burial plots and life insurance policies. Eligibility criteria for SSI are summarized below:

Basic SSI eligibility conditions

Aged	65 or older.
Blind	Vision on better than 20/100 or limited visual field of 20 degrees or less with the best corrective glasses.
Disabled	A physical or mental impairment which prevents a person from doing any substantial work and is expected to last at least 12 months or result in death.
Resource limit [1]	$1,800 in 1987 ($1,900 in 1988) for individuals and $2,700 in 1987 ($2,850 in 1988) for couples.
Income limits [2]	$360 per month in 1987 ($347 in 1988) for individuals, and $530 per month in 1987 ($532 in 1988) for couples.
Citizenship	U.S. citizen, immigrant lawfully admitted for permanent residence, or other persons residing in the United States under color of law.
Residency	Resident of the United States or the Northern Mariana Islands.

[1] Not all resources are counted in determining eligibility.

[2] Reduced benefits may be available for persons earning up to $765 per month in 1987 ($793 in 1988). Not all income is counted in determining eligibility. Also, a person may have income above the limit and possibly be eligible for State supplement only, but the income levels vary among States.

NOTE.—Disabled must accept vocational rehabilitation if available. Drug addicts and alcoholics must accept appropriate treatment if available.

B. ISSUES AND LEGISLATIVE ACTIONS

1. INCOME LIMITS

From a policy perspective, many have criticized the income limits as being too restrictive. The income limits for SSI recipients leave a large number of people who fall below the poverty line ineligible for SSI. (The limit for individuals is $360 per month, or $4,320 per year; for couples it is $530 per month, or $6,360 per year.) Second, the law requires that gifts or inheritance, which may not be readily converted into cash, be treated as income in the month they are received. For instance, if an elderly SSI recipient is given a portable radio by her granddaughter, or inherits a kitchen table from a brother who died, she must report receipt of these gifts to SSA, and their value will be subtracted from her SSI check.

Many have criticized this treatment of gifts as income as a disincentive to family and community involvement in meeting the needs of SSI recipients.

Several important provisions affecting the income limits under the SSI program were included in the Omnibus Budget Reconciliation Act (OBRA) of 1987, signed into Public Law 100-203 on December 22, 1987. The new law eliminates the requirement that Aid to Families with Dependent Children (AFDC) benefits paid prior to an individual's becoming eligible for SSI be counted in determining eligibility for or the amount of SSI benefits due (this problem is caused by retrospective accounting requirements). In addition, it approves a permanent extension of the SSI income disregard provision for in-kind assistance provided by nonprofit organizations and provided on the basis of need. Finally, the reconciliation legislation provides for the exclusion from the SSI income limits any payments provided to the beneficiary as the result of another's death to the extent that these funds were used for payment of the last illness or burial of the deceased.

2. ASSETS LIMIT

The assets limit has increased only slightly since 1974, despite an increase of more than 122 percent in the Consumer Price Index (CPI) over the same period. Today, it would take over $3,000 and almost $5,000, respectively, to purchase what $1,500 and $2,250 could purchase in January 1974, yet these limits have only been raised to $1,800 and $2,700, respectively. After a decade delay in raising the assets limit the Deficit Reduction Act of 1984 included provisions which gradually raise the assets limit to $2,000 for individuals and $3,000 for couples by 1989. The relatively small increases in the assets limit have added to a serious deterioration of the availability of SSI over time.

The cutoff in the SSI assets test also contributes to the problem of overpayment and overpayment recovery in SSI. Currently, if a recipient goes over the limit even a small amount, perhaps from interest in a bank account, that person is deemed ineligible for SSI in the month or months in which there is an excess. This ineligibility usually leads to substantial overpayments, due to the fact that the errors usually are detected only after the full benefits have been paid to the recipient. Approximately 20 percent of all overpayment errors in SSI result from problems associated with bank accounts. Significantly, these errors account for about 50 percent of the dollar amount to be collected as overpayments. This problem was exacerbated by SSA's recent policy of aggressively recovering overpayments, and rarely waiving the obligation to pay back to SSA the funds overpaid.

Though there are significant problems with the assets test, many argue that it serves a critical purpose in ensuring that only people with few or no resources receive benefits, and that eliminating the test would create more problems than it would resolve. For instance, outright elimination of the assets test might open the program to those with limited income, but also would discourage the conversion to cash of significant resources that might otherwise be used for self-support. Other than eliminating it altogether, there are a number of methods for revising the assets test. Congress could, for instance, limit the amount of overpayment incurred by exceeding the assets limits to the dollar amount in excess, or Congress could exclude certain assets, such as insurance policies, from the calculation.

Alternatively, Congress could fold the evaluation of assets into an expanded income test, where assets are translated into an "income stream" over time. Assets would be totaled, and then converted into a stream of cash income, using a set of specific actuarial assumptions (such as life expectancy tables and projected interest rates) to make the calculation. Under the current structure, it is assumed an individual will consume available assets until they drop below the SSI threshold; at that point, income supplementation will begin. Under a plan to annuitize the value of assets, an individual would receive SSI income supplementation while spending down his or her resources over time. This would eliminate the problem of an arbitrary cutoff point for people who are cash poor, but happen to have some available resources. A major problem with this approach is the difficulty of designing the basic assumptions that would guide the valuation of assets over time. Further, such a change could be costly by allowing a large number of presently ineligible individuals to qualify for benefits.

The Senate- and House-passed reconciliation bills included proposals to eliminate the interest earned on burial accounts from consideration as a resource when determining SSI eligibility and to exclude the value of real property for such purposes when it cannot be sold (when the property is jointly owned and its sale would cause undue hardship for the other owner or owners, the property's sale is barred by a legal impediment, or the owner's reasonable efforts to sell the property have been unsuccessful). Both of these proposals were enacted as part of the Omnibus Budget Reconciliation Act of 1987.

In addition, the House approved a provision to allow beneficiaries to transfer assets (given as gifts or sold at below fair market value) up to a combined total of $3,000 without being subjected to penalties or delayed SSI eligibility. As an alternative, the Senate reconciliation package provided that the Secretary of Health and Human Services issue regulations for suspending the transfer of assets rules in cases where such suspension would avoid undue hardship on the beneficiary. The Senate proposal prevailed in the final budget bill.

The House-passed measure also provided that, from January 1, 1987, through December 31, 1988, retroactive SSI and Social Security payments would not be counted as a resource for 12 months. The final budget reconciliation law allowed that for the 2-year period beginning October 1, 1987, retroactive SSI and Social Security payments could be disregarded as a resource for 9 months.

3. BENEFITS

Criticism of the benefit structure in SSI has focused recently on the one-third reduction rule for recipients living in the home of another, and the personal needs allowance for institutionalized recipients. In January 1987, the maximum Federal monthly payment was $340 for an eligible individual ($354 in 1988) and $510 for an eligible couple ($532 in 1988). The law requires a benefit reduction of one-third for those who live in another person's household and who receive support and maintenance from that person or persons. Many groups, including the 1981 National Commission on Social Security, have recommended that the one-third reduction be eliminated. It is a very complex provision to administer, and it serves as a disincentive to SSI beneficiaries to live with others. It has been pointed out that this provision may be counterproductive in that it discourages SSI recipients with mental and physical disadvantages from living with others who may be able to provide support.

Although both primary Senate and House SSI bills (S. 1635, introduced by Senators Pryor and Melcher and H.R. 2795, introduced by Congressman Matsui) included provisions to eliminate the one-third reduction rule, the provision was not included in OBRA 1987. This was ostensibly due to concerns surrounding the estimated $25 million per year cost of implementation.

Other significant criticisms of SSI have been leveled at the benefit treatment of the institutionalized. Persons who permanently or even temporarily reside in public institutions are usually ineligible for, or have limited access to, SSI benefits. While it is true that a person living in a community care facility (serving more than 16 people) can obtain SSI benefits, the benefit—prior to the 1987 reconciliation bill—had been limited to no more than 3 months out of each year. Residents of larger health care institutions in which Medicaid is paying for more than half of that individual's care had been eligible for a small $25 monthly SSI benefit. This money, known as the Personal Needs Allowance (PNA), is intended to cover personal comfort items and had not been increased since 1974. Both of these items, advocates of low-income persons argued, were major shortcomings that contributed to financial hardship for the poor.

In 1987, the following SSI issues relating to those persons living in or receiving temporary medical treatment at institutions were addressed by the 1987 Omnibus Budget Reconciliation Act: (1) The shortcomings of the benefits available to the community care population, (2) the adequacy of the PNA, and (3) the need to protect the full SSI benefit for SSI recipients who had been temporarily placed in an institution for medical care.

The limited SSI benefit available to those person who reside in community care facilities, such as residents of shelters for the homeless, and larger, shared housing arrangements for mentally impaired individuals, received attention by Congress. In past legislative action, SSI benefits were extended for up to 3 months (out of a 12-month period) for otherwise eligible individuals in these public emergency shelters. As a compromise between the Senate- and House-passed reconciliation bills, the final budget reconciliation measure extended the eligibility for benefits for 6 of 9 consecutive months—effectively extending the eligibility to 9 out of 12 months.

Inflation over the past decade has substantially eroded the value of the monthly PNA allowance. Many advocates for the aged have called for an increase in the $25 PNA, arguing that elderly, poor institutionalized persons need and deserve inflation-protected benefits. Opponents of an increase counter that a greater allowance would only lead to increased charges by nursing home operators for those items, such as laundry services, often purchased with PNA funds. The Congress ended up siding with the proponents of the PNA increase and included a $5 per month increase in the 1987 reconciliation law. However, despite this development, no automatic inflation adjustment for the PNA was included in the legislation.

Lastly, the final reconciliation legislation included a provision which allows the continuation of full SSI benefits for individuals placed temporarily in public institutions (primarily for psychiatric or medical care) for 3 months. This provision would allow individuals expected to be released from an institution within a reasonable amount of time to maintain a residence to return to when treatment has been completed.

4. PARTICIPATION

Despite initial projections that over 7 million Americans would participate in SSI, the total SSI caseload has never exceeded 4.5 million. Early assumptions that over 90 percent of the eligible population would benefit from SSI were proven too optimistic; in reality, a more realistic estimate of the participation rate is closer to 60 percent.

These low levels of participation are difficult to explain. Few surveys of the attitudes and opinions of the SSI population have been undertaken, and alternative interpretations of the problem have often been based upon anecdotal information.

Typical explanation of low participation rates in SSI among the elderly include: (a) The stigma associated with welfare, (b) the very small benefit amounts for many potential recipients who are near the maximum income and resource limits, (c) barriers of literacy, mental and physical handicaps, and inadequate transportation, and (d) SSI's administrative complexity.

Both the House and Senate reconciliation packages made improving SSI outreach a priority. OBRA 1987 authorized the funding of SSI Outreach and Eligibility Team Projects (up to a total of 10 demonstrations) modeled after the efforts currently used in New York City to provide outreach and assistance to SSI-eligible individuals in public shelters.

5. ELIGIBILITY OF SSI RECIPIENTS FOR OTHER PUBLIC ASSISTANCE PROGRAMS

SSI recipients often qualify for additional Federal public assistance from a variety of programs, most notably Medicaid and Food Stamps. The relationship between SSI and Food Stamps has changed over the last decade. Originally, SSI beneficiaries were prevented by the statute from receiving Food Stamps. This exclusion was eliminated in 1977 by Congress, by virtue of the fact that it seemed inequitable that AFDC recipients, as well as people whose income or assets exceeded SSI limits, could qualify for Food Stamps while SSI beneficiaries could not. Currently, SSI recipients can apply for Food Stamps in SSA district offices, where eligibility determinations are made in accordance with conventional Food Stamp guidelines. In California and Wisconsin, Food Stamps are "cashed out," or converted into cash as part of monthly SSI payments.

States are required to offer Medicaid to SSI recipients if the recipients are eligible under the State's 1972 eligibility criteria. The 1972 legislation creating SSI gave States the option of allowing SSA to determine Medicaid eligibility, if the States were willing to accept SSI eligibility as a condition for Medicaid coverage. Currently, more than half the States allow SSA to execute Medicaid determinations for SSI recipients. Medicaid is perhaps the most valuable ancillary Federal program for SSI beneficiaries, and adds significantly to the adequacy of SSI coverage.

Medicaid is often more important to many SSI recipients than cash benefits, and there are a number of instances in which small increases in outside income, and corresponding ineligibility for SSI, will cause the loss of Medicaid benefits. For instance, a 60-year-old widow may become eligible for Social Security widow's benefits and concurrently lose eligibility for SSI and Medicaid, while not becoming eligible for Medicare. The loss of Medicaid often far outweighs the value of the increase in cash benefits to these individuals.

Another area of concern is the effect of assistance provided by private nonprofit organizations to SSI recipients (e.g., free food from soup kitchens or help with utility bills) on their eligibility. Those who advocate including this type of aid in countable income point out that SSI is a strict, means-tested program, and to the extent that applicants or recipients have available means, whether earned or provided for free, they should be evaluated against the objective standards that limit eligibility for benefits. Opponents of this policy argue that such assistance should be excluded from countable income, particularly because it serves the emergency needs of many very low income recipients, placing the poor in the catch-22 of qualifying for aid and then losing it because of other assistance. Also, counting this aid as income discourages charitable involvement in providing for the poor. (Legislative action regarding this concern is discussed in Income Limits, above.)

In 1987, three proposals affecting the extension of Medicaid benefits to SSI beneficiaries were accepted by the House and Senate as part of their respective budget reconciliation packages and were therefore included in OBRA 1987. First, the provision of law giving States the option to prevent a reduction or termination of Medicaid benefits was strengthened to assure that a couple could be eligible for this benefit regardless of whether or not they resided in the same room of an institution. Second, it extended Medicaid eligibility to certain SSI beneficiaries who are made ineligible by virtue of becoming eligible for early widow's or widower's Social Security benefits. Finally, the budget measure extends the deadline for disabled widows to apply for Medicaid protection under the 1983 Social Security amendments from July 1, 1987, to July 1, 1988.

6. EMPLOYMENT AND REHABILITATION FOR SSI RECIPIENTS

One of the basic objectives of SSI was to create a public assistance program that had the least possible disincentives to employment. At no time, however, has more than a tiny fraction of the

SSI caseload received income from earnings (in December 1983, for instance, only 3.3 percent of all recipients reported earnings).

The low rate of employment of SSI recipients is a product of a number of factors. First, SSI recipients under age 65 are by definition severely disabled. Even those who might have some limited capacity to work have difficulty finding suitable employment. Second, there are major work disincentives built into the structure of SSI. For instance, an individual may be able to secure earnings that are more advantageous than the SSI benefit, but the loss of Medicaid coverage, given the difficulty of obtaining substitute health insurance with a pre-existing condition, more than offsets the increased income.

The Social Security Disability Amendments of 1980 (Public Law 96–265) included changes that were meant to encourage SSI recipients to seek and engage in employment. The relevant provisions, which became section 1619 of the Social Security Act, were designed to lessen the substantial disincentives to work under SSI. The 1980 amendments: (a) Continued special monthly benefits, as well as Medicaid eligibility, for disabled recipients who have completed the 9-month trial work period and continue to receive earnings in excess of SSI income limits; (b) provided that impairment-related work expenses (including medication, attendant care, special equipment) could be deducted from countable income; and (c) treated money earned in sheltered workshops as earned, rather than unearned income, for the purpose of calculating benefits.

The law limited these provisions to a temporary, 3-year trial period that expired on December 31, 1983. They were extended another 3 years in 1984, with the passage of the Social Security Disability Benefits Reform Act.

On November 10, 1986, the Employment Opportunities for Disabled Americans Act (Public Law 99–643) was signed into law. The legislation made a number of improvements in the section 1619 program, including making permanent the section 1619 benefits (allowing disabled SSI recipients to earn as much as $765 per month in 1987 before benefits are completely phased out) and allowing the working disabled to maintain eligibility for Medicaid until their earnings exceed the wage income limit plus the value of State supplements. The law also eliminated the Trial Work Period and the Extended Period of Eligibility effective upon enactment of the other improvements (July 1, 1987). In January 1986, it was estimated that 992 people received special SSI benefits and 8,106 recipients took advantage of the extended Medicaid benefits.

The relatively low level of utilization of these special benefits offered by the 1980 amendments appears to be a product of the fact that few are aware of the existence of the provisions and the fact that employment will not automatically terminate eligibility for SSI and Medicaid.

7. OTHER SSI BUDGET RECONCILIATION ISSUES

A number of other provisions of note relating to SSI were included in the Omnibus Budget Reconciliation Act of 1987. Two of these provisions dealt with the special needs of the blind. The first was a requirement that the SSA provide blind SSI applicants and recipients the option of receiving supplementary notice (e.g., by telephone or certified letter) of any action taken or proposed regarding their benefits or eligibility for benefits. In addition, OBRA 1987 included provisions to continue the availability of benefits to blind SSI recipients whose disabilities have improved but who continue participation in approval vocational rehabilitation programs. In addition, under both bills the limit on emergency advance payments for individuals who are presumptively eligible for SSI benefits was raised from a maximum of $100 to the amount of the monthly SSI benefit standard plus any State supplementary payment the beneficiary may be receiving.

The only other major SSI issue addressed in the reconciliation measure was one pertaining to SSI interim assistance payments. Under current law States may provide interim assistance payments to individuals who are awaiting initial eligibility determinations. If benefits are approved, SSA reimburses the States for the interim payments granted. Under the House reconciliation bill, States also would be permitted to provide interim assistance payments in cases where benefits have been terminated or suspended (but eligibility is subsequently granted), or in the case of lost or stolen checks which have not been promptly replaced. The Senate legislation included similar language, but did not include the provision regarding lost or stolen checks. The Senate provision prevailed in the final budget legislation.

C. PROGNOSIS

Throughout its history, SSI has been considered an essential element of the safety net of programs which protect the Nation's least advantaged citizens. This role has protected the program from major cuts in recent years, but pressure on the budget has nonetheless prevented the program from expanding and from keeping pace with inflation. Given the decision to exclude SSI from the automatic budget cuts of Gramm-Rudman-Hollings, it is likely that Congress will continue to insulate the program from cuts. However, increasing pressure to reduce Federal budget deficits will most likely prevent growth of the program in the near future. Nonetheless, program advocates can be expected to continue attempts to raise benefits to the poverty level, improve access to the program, and eliminate perceived harsh aspects of program administration. Unsuccessful legislative efforts in 1987 may well serve as a good starting point for such initiatives in the future.

Chapter 7

FOOD STAMPS

OVERVIEW

Appropriations for the Food Stamp Program were authorized through fiscal year 1990 by the 1985 Food Security Act (Public Law 99-198). This same law made significant changes that liberalized the program and are expected to add more than $1 billion in new spending through 1990. As a result, in 1986 and again in 1987, Congress chose to address only a limited agenda of revisions to the Food Stamp Program.

In 1986, Congress acted to:

(1) Increase homeless households' access to the program (Public Law 99-570),

(2) Give States greater flexibility in verification of applicants' and recipients' income through procedures that match information they supply with other information available to welfare offices from the Social Security Administration, unemployment insurance agencies, and the Internal Revenue Service (Public Law 99-509),

(3) Call for the establishment of an automated system for verifying aliens' eligibility (Public Law 99-603), and

(4) Expand the degree to which education assistance is disregarded in determining food stamp eligibility and benefits (Public Law 99-498).

The most significant 1986 food stamp amendment affecting the elderly was the requirement, enacted in Public Law 99-425, that benefits under the Low-Income Home Energy Assistance Program (LIHEAP) not affect food stamp benefits. LIHEAP benefits are not counted as income for food stamp purposes and recipients are allowed to deduct all utility expenses (including those paid by LIHEAP) when their income for food stamp eligibility is calculated.

Although the administration put forward a number of proposals affecting the Food Stamp Program in the fiscal year 1988 budget, Congress largely ignored them and, instead, chose to pursue a separate legislative agenda.

The administration's most recent proposals for food stamps were directed primarily at increasing collections of sanctions from States with high rates of erroneous benefit payments. However, some benefit changes were put forward. Food stamp benefit reductions were recommended for LIHEAP recipients as well as participants in Job Training Partnership Act programs and recipients in Puerto Rico's nutrition assistance program.

Congress, on the other hand, took a different approach. It approved benefit increases in the Stewart B. McKinney Homeless Assistance Act (Public Law 100-175) and the Charitable Assistance and Food Bank Support Act (Public Law 100-232). In addition, the House of Representatives adopted further program liberalization in the Food Stamp Family Welfare Reform Act (H.R. 3337, as included in H.R. 1720). Finally, Congress began consideration of various proposals to revamp the food stamp quality control system—the procedures under which States are penalized for having high rates of erroneous benefit payments.

A. BACKGROUND

The Food Stamp Program attempts to alleviate malnutrition and hunger among low-income persons by increasing their food purchasing power. It forms a national benefit floor by issuing food stamps to combine with income already available to the recipient household to purchase a more nutritious diet than would be possible without food stamps. As of August 1987, 20.1 million low-income persons participated in the program, with an average monthly benefit of $46 per person. This includes about 1.5 million persons a month in Puerto Rico under the nutrition assistance block grant program that has replaced the Food Stamp Program there. The Food Stamp Program is available to households meeting its assets and income tests or who already are receiving benefits from the Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) programs. It is estimated that 30-35 million people in the United States actually may be eligible to receive food stamps. The following table provides an historical overview of the Food Stamp Program from 1979 through 1987.

TABLE 1.—HISTORICAL FOOD STAMP STATISTICS

Fiscal year	Total Federal spending [1] (millions)	Average monthly participation (millions of persons)	Average monthly benefits (per person)	Maximum monthly allotment (4 persons) [2]
1979	$6,995	17.7	$30,60	$182
1980	9,188	21.1	34.40	204
1981	11,308	22.4	39.50	209
1982	11,117	[3] 21.7	39.20	233
1983	12.734	[3] 23.2	[4] 43.00	[4] 253
1984	12,470	[3] 22.4	[4] 42.70	[4] 253
1985	12,599	[3] 21.4	[4] 45.00	[4] 264
1986	12,529	[3] 20.9	[4] 45.50	[4] 268
1987 (est.)	12,540	20.5	45.80	271

[1] Includes spending for Puerto Rico's nutrition assistance program.

[2] For the 48 contiguous States and the District of Columbia at the beginning of each fiscal year.

[3] Includes recipients in Puerto Rico: 1.6 million persons in fiscal years 1982 and 1983; 1.5 million persons in fiscal years 1984, 1985, and 1986.

[4] Does not reflect lower benefits in Puerto Rico.

Source: Congressional Research Service.

The origins of the Food Stamp Program began as a group of pilot projects set up by Executive order in 1961 when the Federal Government began a small, experimental anti-hunger program in eight counties. Today's Food Stamp Program began with the Food Stamp Act of 1964, which offered States the option of operating a Food Stamp Program in lieu of existing commodity donation programs. In 1977, Congress enacted the Food Stamp Act of 1977, which completely revamped the Food Stamp Program's operation. Since then, Congress has enacted amendments intended to improve the program and strengthen its integrity.

Eligible applicants receive food coupons in amounts determined by household size and income to buy food through normal market channels, primarily in authorized grocery stores. The stamps are forwarded by the grocery stores to commercial banks for cash or credit. The stamps then flow through the banking system to the Federal Reserve Bank where they are redeemed out of a special account maintained by the U.S. Treasury Department. The Food Stamp Program serves as an income security program by supplementing family income. It also contributes to farm and retail food sales and helps reduce surplus stocks by encouraging increased food purchases.

Recent studies, confirming a correlation between nutritional status and health, particularly to the elderly and children, underscore the tremendous importance of the Food Stamp Program. The program has some special rules for the elderly—including more liberal treatment of shelter costs, medical expenses, and assets. The program, for example, recognizes that elderly people with high medical bills may have total incomes higher than the poverty line, but no more money actually available for food than those with lower incomes and no medical bills. For the 12.5 percent of the elderly that took the medical deduction for the elderly and disabled, the average deduction was $61 per month.

Although 21 percent of food stamp households have at least one elderly member (age 60 or older), they make up only 8 percent of all food stamp recipients and receive 9 percent of food stamp benefits (an average of $31 per month) because of the typical small size of elderly households. Twenty-nine percent of the elderly who receive food stamps receive only the minimum benefit of $10 a month. Ninety-one percent of all elderly participants live alone or with one other person, usually elderly as well; 72 percent, usually women, live alone. More than 13 percent of elderly households also include children. Eighty-nine percent of elderly recipients have assets of $500 or less, with an average of $154 per household.

The Federal Government pays 100 percent of all food stamp benefits and 50 percent of most State and local administrative costs. State and local costs for computerization and fraud control activities are eligible for 75 percent Federal funding. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At State and local levels, the Food Stamp Program is administered by State welfare departments.

Uniform national household eligibility standards for program participation are established by the Secretary of Agriculture. All households must meet a liquid assets test and, except for those with an elderly or disabled member, a two-tiered income test to be eligible for benefits. Recipients of two primary Federal-State categorical cash welfare programs—AFDC and SSI—automatically are eligible for food stamps, although in California and Wisconsin increased SSI benefits replace food stamp assistance. The household's monthly gross income must not exceed 130 percent of the income poverty levels set annually by the Office of Management and Budget (OMB), and its monthly income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty level.

The limits on countable and gross income in the 48 States, the District of Columbia, the Virgin Islands, and Guam are as follows, through September 1988:

TABLE 2.—COUNTABLE AND GROSS INCOME ELIGIBILITY LIMITS THROUGH SEPT. 30, 1988

Household size	Countable income limits [1] (per month)	Gross income limits [1] (per month)
1 person	$459	$596
2 persons	617	802
3 persons	775	1,008
4 persons	934	1,214
5 persons	1,092	1,420
6 persons	1,250	1,625
7 persons	1,409	1,831
8 persons	1,567	2,037
Each additional member	+159	+206

[1] Limits are higher in Alaska and Hawaii, by 25 and 15 percent, respectively.

Source: Congressional Research Service.

To be eligible, a household cannot have liquid assets exceeding $2,000 or $3,000 if the household has an elderly member. The value of a residence, household belongings, business assets, burial plots, threshold amount for an automobile and certain other resources are excluded from the liquid assets limit.

Certain able-bodied adult (older than 16–18, depending on their school and family status) household members who are not working must register for employment and accept a suitable job if offered in order to maintain eligibility. States are required to operate work and training programs under which adults registered to work and not exempted must fulfill State work program requirements. These may include workfare obligations, supervised job search requirements, participation in a training program, or other employment or training activities designed by the State.

Applicant households certified as eligible are entitled to a specific level of benefits—generally in the form of food coupons, which are accepted by authorized grocery stores in exchange for food. A food stamp household is expected to spend 30 percent of its cash income for food with the food stamp benefit making up the difference to buy an adequate low-cost diet based on USDA's Thrifty Food Plan, which determines the benefit level. In fiscal year 1988, the maximum food stamp benefit is $87 a month for a one-person household and $159 for a two-person household. Benefits in 1987 averaged $46 per person per month although the average was significantly lower for the elderly.

Maximum monthly food stamp allotments, from which 30 percent of a household's monthly countable income is taken to determine the household's actual benefit, are as follows:

TABLE 3.—MAXIMUM MONTHLY FOOD STAMP ALLOTMENTS

[Effective October 1987–September 1988]

Household size	48 States and District of Columbia	Alaska [1]	Hawaii	Virgin Islands	Guam
1 person	$87	$113	$133	$111	$128
2 persons	159	207	244	205	235
3 persons	228	297	350	293	336
4 persons	290	378	444	373	427
5 persons	344	448	527	443	508
6 persons	413	538	633	531	609
7 persons	457	595	700	587	673
8 persons	522	680	800	671	770
Each additional person	+65	+85	+100	+84	+96

[1] These allotment levels are for urban Alaska. Benefit levels for various rural areas of Alaska are generally 30- to 50-percent higher.

Source: Congressional Research Service.

B. ISSUES

In the first session of the 100th Congress, and after many years of debate about the extent of hunger in the United States, legislative attention focused on liberalizing certain rules of the Food Stamp Program with the intent of improving the nutrition of the homeless. Framing this debate were alternative assumptions about the extent of hunger in the United States and the role and adequacy of food stamps in combating it. Previous debate of the 99th Congress on whether the program had become too liberalized, justifying further cutbacks and tighter eligibility requirements, or needed to be expanded, faded in the wake of new research findings and congressional lack of attention to Administration efforts at program curtailment.

Involvement in "welfare reform" initiatives by making changes in the Food Stamp Program to complement proposed legislation in the House of Representatives for the cash welfare system is another continuing issue as welfare reform legislation progresses in the 100th Congress. The long-standing controversial issues regarding quality control, by which States are required to identify and measure incorrect food stamp eligibility determinations and issuances, are gaining increased attention. Recently released congressionally mandated studies and fiscal sanctions owed by the States totaling more than $500 million will accelerate the pressure for a legislative reworking of the system.

1. The Hunger Program Expansion Debate

The first major publicity about hunger in America came after a visit to the rural South in April 1967, by members of the Senate Subcommittee on Employment, Manpower and Poverty to hold hearings on the effectiveness of the so-called war on poverty. Members of the subcommittee were told of hunger and poverty and later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. When the physicians returned in 1977 to evaluate progress made in combating hunger, they found dramatic improvements in the nutritional status of individuals in those same areas which were attributed to the expansion of Federal food programs in the 1970's.

Throughout the 1980's, considerable attention has focused on the re-emergence of widespread hunger in the United States. Since 1981, at least 32 national and 43 State and local studies on hunger have been published by a variety of government agencies, universities, and religious and policy organizations. They all suggest that hunger in America is widespread and entrenched, despite national economic growth.

In 1981, news accounts of bread lines and crowded soup kitchens began to appear in papers in various cities around the country. In 1982, the U.S. Conference of Mayors reported that in most cities surveyed, the need for food represented a serious emergency. In 1983, the Conference issued a report which detailed a dramatic increase in requests for emergency food assistance with unemployment cited as a primary cause.

Closely following that report, the General Accounting Office reported significant increases in the number of persons seeking food assistance during the past few years, including increasing numbers of persons who recently had been financially stable. In 1983, Senator Edward Kennedy issued to the Senate Committee on Labor and Human Resources, a report based on a field investigation undertaken the week before Thanksgiving. In his report, Senator Kennedy found that hunger was on the rise in America and that Congress must act to improve assistance to the hungry.

The Center on Budget and Policy Priorities surveyed private nonprofit agencies which operate emergency food programs across the Nation and reported in 1983 that more than half of the 181 programs surveyed increased the number of free meals or food baskets they provided by 50 percent or more from 1982 to 1983. Nearly one-third of the programs also doubled in size over that time.

Later that year, President Reagan appointed a commission to investigate allegations of rampant hunger in the United States. At the end of 1984, the President's Task Force on Food Assistance concluded in its report that there was little evidence of widespread hunger in the United States and that reductions in Federal spending for food assistance had not caused hardship to the poor. Several modest recommendations to make the Food Stamp Program more accessible to the hungry were outlined in the report, including:

(1) Raising asset limits,

(2) Increasing the food stamp benefit to 100 percent of the Thrifty Food Plan,

(3) Categorical eligibility for AFDC and SSI households,

(4) Targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled), and

(5) Modification of the permanent residence requirement so benefits are available to the homeless.

These liberalizations, however, were offset by cost-reduction measures which included increasing the State responsibility for erroneous payments and an optional State block grant for food assistance.

The Food Research and Action Center (FRAC) also surveyed nationally the use of emergency food programs during the early 1980's. In 1983, FRAC found that food stamp recipients were the majority users of emergency food programs, mostly because they ran out of stamps by the second or third week of the month. It was reported that those who did not receive food stamps either did not know they were eligible, had applied and had been turned down, or did not know how or where to apply. FRAC also reported that between 1983 and 1984, there was an average monthly increase of 20.4 percent in the number of households served nationally by emergency food providers and a 17-percent-per-month increase between 1984 and 1985. The 1983 study concluded that, as a result of budget cuts and changes in the law, the Food Stamp Program no longer was adequately assisting the eligible poor nor reaching the population at risk of hunger.

The Harvard School of Public Health, after 15 months of research into the problem of hunger in New England, concluded in 1984 that:

(1) Substantial hunger exists in every State in the region,

(2) Hunger is far more widespread than generally has been realized, and

(3) Hunger in the region had been growing at a steady pace for at least 3 years and was not diminishing.

The researchers found the elderly frequenting emergency food programs in greater numbers and often suffering in the privacy of their homes, either because it was difficult for them to get out or because they chose to suffer alone and no longer had anyone to prompt them to leave their home for food. The staff also expressed concern over what had been noted in clinical practices: Increasing numbers of malnourished children and greater hunger among their patients, including the elderly. The staff also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

The Physicians Task Force on Hunger in America, established in 1984, has issued periodic reports on the nature and scope of the hunger problem, including regional and group variations. Through the Harvard School of Public Health, it also has assessed the health effects of hunger and made recommendations to remedy the problem. Its first report in 1984 concluded that hunger was of epidemic proportions across the Nation, was getting worse, and was the result of Federal policies. The report estimated that up to 20 million Americans may be hungry at least some period of time each month.

In 1986, the Task Force identified 150 "hunger counties" in the United States with high poverty levels and low food stamp participation. A high concentration of hunger counties was identified in the Midwest and North Central States. The report concluded that the level of participation in the Food Stamp Program appeared to be related to a county's effort to enroll the poor in the program rather than a high poverty rate in the county.

Later that year, The Task Force issued another report about barriers to participation in the Food Stamp Program to determine why food stamp coverage was declining when hunger was increasing. It concluded that, while poverty had increased between 1980 and

1985, food stamp participation by those eligible had decreased because of conscious Federal policy changes that resulted in barriers to food stamp participation and limited State and local Food Stamp Programs from reaching more needy people. Many recommendations were made to provide outreach, increase access, and liberalize the program.

In 1987, the Physicians Task Force on Hunger issued a report which noted that, despite 5 years of economic growth, hunger had not been reduced significantly. More people are living in poverty, many of them the working poor and the long-term unemployed, the report found. It cited a strong downward pressure on wages with the share of after-tax household income dropping for every income category since 1980 except the highest 20 percent. It argued that whole new categories of individuals have entered the hunger ranks, citing field investigations into the situations of former oil workers in the South, farm families in the Midwest, and service workers of California, as well as miners and steelworkers. It noted that 25 percent of the population lives at the poverty level at some time during the year, that the income gap between rich and poor families had reached its widest point in four decades, and that Government programs designed to assist the poor have less impact than in 1979.

A study released in 1986 by Public Voice for Food and Health Policy found that the rural poor were less likely to consume adequate levels of nutrients than were the nonpoor and that rural poor children experienced stunted growth at an alarming rate. Low birth weights and high infant mortality rates were found to be significantly higher in poor rural counties than in the rest of the Nation. Also, according to 1983 data, while the highest percentage of the elderly population who live in poverty live in rural areas, only 31 percent of these rural poor elderly households receive food stamp benefits. The study also concluded that the rural poor were significantly less likely to participate in most assistance programs.

According to medical experts on aging, malnutrition may account for a substantially greater portion of illness among elderly Americans than long has been assumed. The concern about malnutrition is rising fast as the numbers of elderly climb and as surveys reveal how poorly millions of them eat. The New York Times reported in 1985 that scientists estimate that from 15 percent to 50 percent of Americans over the age of 65 consume too few calories, proteins, or essential vitamins and minerals for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in disease resistance seen in elderly patients—a weakening of immunological defenses that commonly has been blamed on the aging process. Experts say that many elderly fall into a spiral of undereating, illness, physical inactivity, and depression. The recent findings suggest that much illness among the elderly could be prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold out the promise that many individuals can lighten the disease burden of old age by eating better. And being poor greatly exacerbates the effect of nutrition problems. Low participation in the Food Stamp Program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

A 1987 National Survey of Nutritional Risk Among the Elderly by the Food Research and Action Center found that 18 percent of the low-income elderly who responded said they did not have enough money to buy the food they needed, 35 percent usually ate less than 3 meals a day, and 5.4 percent were without food for more than 3 days in the last month. Yet about a third of this sample seldom or never participated in congregate meals programs and only about 25 percent participated in the Food Stamp Program.

A 1985 report by the General Accounting Office (GAO), based on research conducted by private organizations and the U.S. Department of Agriculture (USDA), as well as the President's Task Force on Food Assistance concluded that nonparticipation in the Food Stamp Program by many low-income households was attributable to many factors. They include:

(1) A lack of information regarding eligibility,

(2) The amount of potential aid not being enough to warrant the time and effort to apply,

(3) Administrative requirements such as complex application forms and required documentation,

(4) Physical access problems such as transportation or the physical condition of the potentially eligible applicant, and

(5) Attitudinal factors, such as households being sensitive to the social stigma associated with receiving food assistance.

One 1982 study estimated that only 50 percent of eligible elderly in the United States participate in the Food Stamp Program. Participation was very low among elderly people living alone, and the older people are, the less likely they are to participate. A lack of information about eligibility seems to be a key factor; 33 percent of eligible nonparticipants did not think they were eligible for food stamps and another 36 percent said they did not know whether they were eligible.

Critics of the adequacy of the Food Stamp Program have made a number of recommendations for improvement and expansion of the program. They cite that the Food Stamp Program has been subject to substantial budget reductions through congressional budget cuts and administrative changes designed to limit abuse of the program. Overall, the Congressional Budget Office (CBO) has estimated that legislative measures taken in 1981 and 1982 held food stamp spending for fiscal years 1982-85 nearly $7 billion below what would have been spent under pre-1981 law. This translated into a 13-percent reduction at a time when poverty was at its highest level in nearly two decades. For most recipients, the changes did not lead to a direct reduction in benefits, but simply delayed or lowered benefit increases scheduled under previous law. About 1 million people, however, lost eligibility for food stamps due to changes in the law and some recipients received reduced benefits due to administrative changes.

Opponents of expansion and liberalization of the Food Stamp Program criticize the accuracy of some of the studies and the alleged cause of extended hunger as being due to Federal program reductions. They maintain that Federal food assistance programs have been expanded in recent years, that benefits are available to any eligible person and generally are inflation-indexed and protected from budget reductions. Critics of proposals for expansion also urge that the Federal budget deficit is a limiting factor and that the loosening of eligibilty and other limits might undermine program integrity.

Proposals to improve access are the most common recommendations for expansion of the Food Stamp Program. These include increased funding, easing procedures for applying for and receiving benefits, and expanding participation through outreach and other activities. Others argue that food stamp benefits are not sufficient and should be expanded through an increased allotment or adjustments in deduction levels. Other proposals include easing eligibility rules for assets and household makeup.

2. FOOD STAMP FAMILY WELFARE REFORM

More comprehensive efforts to tie the Food Stamp Program into the rest of the welfare system are being attempted with this proposed legislation. However, it would primarily affect families with children rather than elderly households. It would increase coordination between the benefits and administration of the Food Stamp Program and the rest of the welfare system, complement other welfare reform under consideration by Congress and improve the employment and training features of the Food Stamp Program. However, these proposals raise a number of questions, including:

(1) Whether the welfare reform initiative to which it is attached is the right approach,
(2) The cost of the proposed changes,
(3) Whether States should be allowed additional authorization to experiment with food stamp and other welfare program rule changes, and
(4) Whether the proposed changes actually offer incentives to remain on welfare.

3. QUALITY CONTROL AND FISCAL SANCTIONS

As do other welfare programs, the Food Stamp Program has a quality control review system. Established by the Food Stamp Act of 1977, it requires States, with Federal oversight, to monitor their programs to identify and measure incorrect food stamp eligibility determinations and issuances. Errors may range from fraud, obtaining insufficient information, or simple arithmetic mistakes. Cases may include issuing too many or too few food stamps or improperly denying eligibility.

Beginning in fiscal year 1981, a system of monetary sanctions was put in place to create a financial incentive for States to improve program administration. Amendments passed by Congress in 1982 required States to progressively reduce their error rates (for overpayments and payments to ineligible households) to avoid sanctions. Beginning in fiscal year 1985, States must keep their error rates at 5 percent or below to avoid sanctions. However, almost all States have failed to meet targets for error reduction and sanctions assessed by the Federal Government have risen precipitously to about $508 million for fiscal years, 1983-85. Most recent estimates place the average "error rate" at 8 percent nationwide which would result in more than $800 million in erroneous payments. This is a one-third improvement over the 11.8 precent average error rate of late 1976.

Few of these sanctions have been collected, as they have been challenged by the States through administrative appeals and the Federal courts. States and other critics have found problems with the statistical soundness and other factors that affect the error monitoring system and the amount of assessed sanctions. The administration, on the other hand, views the current sanction system as too weak, and continuously makes proposals to increase sanctions and hasten collections.

Congress responded to the State's criticisms of the quality control program by mandating two studies of the system in 1985 (Public Law 99-198), one by the Department of Agriculture and the other by the National Academy of Sciences. The same law also put a moratorium on the collection of sanctions through June 1986.

The two studies of the food stamp quality control system were released in the spring of 1987. The Agriculture Department found its system basically sound in its implementation and statistical methodology, but indicated that some improvements might be acceptable. On the other hand, the National Academy of Sciences study found significant problems, recommended a major overhaul of the system, and called for the recalculation and lowering of sanctions already assessed to the States.

Studies of the food stamp quality control system by the General Accounting Office also have been critical of the program. Two 1987 reports focused on an evaluation of the system's treatment of improper eligibility terminations and denials. The study found that the States have not focused closely enough on the part of the quality control system intended to measure effectiveness in assuring that eligible households are not denied erroneously or terminated from food stamp benefits with the result that the number of these households are seriously underreported. Some of the States responded that this could be attributed to States being held liable for overpayments but not for improper denials or terminations. The Department of Agriculture has acknowledged that it has emphasized overissuance determinations as opposed to determinations of improper denials or terminations, and has agreed to look into the feasibility of combining error rates and a sanction system for improper denial or termination error rates.

As a result of the studies, congressional hearings and other information, corrective legislative and regulatory action for the food stamp quality control system is underway. The major issues to be addressed are:

(1) Sanctions already assessed but not yet collected,

(2) Revision of the methodology for collecting future sanctions,

(3) Whether the current 5 percent tolerance level floor should be changed,

(4) Whether and how statistical methods should be revised,

(5) Whether and how to expand the system to cover other measures of program quality beyond overpayments, and

(6) Whether and how the administrative appeals process might be revised into a speedier process.

Underlying any decisions for improving the quality control program will be the broader questions of balancing incentives for accurate and effective State administration versus a realistic appraisal of the States' actual ability to achieve certain performance standards.

(A) THE FOOD SECURITY ACT OF 1985

Title XV of the Food Security Act of 1985 (Public Law 99-198) extends the food stamp appropriations authorization through fiscal year 1990, with appropriations ranging from $13 billion in 1986 to $16 billion in 1990. It also makes changes in the program that are expected to add about $800 million in new food stamp spending over the next 5 years plus nearly $300 million to the current $825-million-a-year nutrition assistance block for Puerto Rico.

Substantial changes affecting the elderly include:

(1) Automatic food stamp eligibility for AFDC and SSI households (without the special income limit proposed by the Senate, but not including SSI recipients in California and Wisconsin),

(2) An increase in the liquid assets limitation for single-person elderly households from $1,500 to $3,000 (the existing $3,000 limit for households of two or more with an elderly member is not changed and the limit for nonelderly households is increased from $1,500 to $2,000),

(3) Reinforcement of requirements for food stamp services at Social Security offices,

(4) Expansion of the number of pilot projects allowing the use of simplified application and standardized benefit procedures for AFDC, SSI, and Medicaid recipients, and

(5) Extension of pilot projects for cash payment of food stamp benefits for the elderly.

Also included were new initiatives, benefit increases, and eligibility liberalizations:

(1) A requirement for States to establish employment and training programs for employable recipients with performance standards set by the Federal Government,

(2) A prohibition on the collection of sales taxes on food stamp purchases,

(3) An increase in the earned income deduction from 18 percent to 20 percent along with an increase in the degree to which high shelter expenses and dependent-care costs are taken into account in food stamp benefit computations,

(4) An expansion of the definition of "disabled person,"

(5) More liberal treatment for households with self-employment income,

(6) Liberalization of the rules governing disqualification for failure to meet work requirements,

(7) Liberalization of student eligibility rules,

(8) A 6-month moratorium on collection of fiscal sanctions from States, coupled with a study of the food stamp quality control system and revision of the system based on the study's results, and

(9) Increases in the nutrition assistance block grant for Puerto Rico.

Benefit reductions in the act are:

(1) Earnings received by on-the-job trainees under Job Training Partnership Act programs will be counted as income for food stamp purposes, except in the case of dependents under age 19,

(2) Most rules that disregard the portion of education aid not paid for tuition and mandatory fees (i.e., available for living expenses) will be removed,

(3) Most rules which disregard the portion of cash welfare grants diverted through third parties will be removed, and

(4) In a few cases, those food stamp recipients who also get aid under the Low-Income Home Energy Assistance Act may have limits placed on the extent to which they can use utility expenses to reduce their countable income.

(B) 1986 LEGISLATION

In 1986, Congress made several major changes in food stamp law, liberalizing:

(1) Treatment of student income from Federal programs,

(2) Treatment of Low Income Home Energy Assistance Program (LIHEAP) payments for food stamp recipients,

(3) Rules regarding the use of food stamps by the homeless, and

(4) Eligibility of the homeless.

Under the Higher Education Act Amendments (Public Law 99-498), certain income received from Federal higher education aid programs is exempt from income used to determine food stamp eligibility and benefits. The new amendments expanded the exempt income category to include allowances for books, supplies, transportation, and miscellaneous personal expenses. Previous law exempted only the portion of any grant or deferred-repayment loan used for tuition and mandatory fees.

The 1986 law reauthorizing the Low Income Energy Assistance Program (LIHEAP) (Public Law 99-425) exempts LIHEAP benefits from food stamp eligibility. All households receiving LIHEAP benefits claim the entire amount of their utility costs as shelter expense regardless of whether LIHEAP assistance covers the expense.

Under the Food Stamp Program, both gross and "countable" income affect eligibility and benefit determinations. Gross income is all cash income to a household, less allowed exclusions. It is used in determining a household's income eligibility. Households without an elderly or disabled member must have gross monthly income below 130 percent of the Federal poverty level to be eligible. LIHEAP benefits are excluded by law and, thus, have no effect on a household's gross income eligibility determination.

Countable income is a household's gross monthly income, less certain deductions for living expenses. It is used for determining a household's income eligibility and food stamp benefit. Because LIHEAP benefits are excluded from the computation of the gross income base, they have no direct effect on countable income. However, because shelter expenses, including utility bills, might qualify a household for an excess shelter expense deduction and thereby reduce countable income, the treatment of utility expenses covered by LIHEAP benefits is important.

Previously, LIHEAP recipients were treated in a number of ways with regard to their utility expenses and food stamp determinations. In a number of States, LIHEAP recipients were allowed to claim, as a shelter expense, the entire amount of their utility bills, regardless of whether the LIHEAP benefit is in the form of a cash payment to the household or a "vendor" payment made to the utility provider. In other States, Federal food stamp regulations generally were followed. These rules allowed LIHEAP recipients receiving their benefit as a cash payment to claim the entire amount of their utility costs as a shelter expense, but allowed those receiving benefits as a vendor payment to the utility provider to claim only the portion of costs that they pay themselves.

Under provisions of the Anti-Drug Abuse Act (Public Law 99-570) enacted in 1986, the homeless would be allowed to voluntarily use their food stamps for prepared meals served by public or private nonprofit establishments such as shelters and soup kitchens. Exceptions for the use of food stamps in purchasing prepared meals previously had been made for elderly participants in meal service programs, drug addicts and alcoholics in treatment programs, and residents of shelters for battered women and children. Other provisions included requiring the Social Security Administration (SSA) to make regular visits to homeless facilities to take SSI and food stamp applications and requiring SSA and the Agriculture Department to develop procedures to take SSI and food stamp applications from people about to be discharged from medical, penal, and other institutions.

(C) THE ADMINISTRATION'S 1987 PROPOSALS

In its submission of the fiscal year 1988 budget, the administration again proposed substantial changes in food stamp law intended to produce cost savings of $600 million in fiscal year 1988 based on the $13.1 billion it estimated would be necessary for the program under current law and administrative practices. This would hold costs at about $12.5 billion, about the same amount that was estimated to have been spent in fiscal year 1987 under an appropriation of $12.646 billion.

The proposed revisions advanced by the administration in 1986 were rejected by Congress. In 1987, these proposals, again largely were ignored by Congress. The majority of the cost-saving measures proposed by the administration were aimed at collecting money from the States by recovering sanctions imposed for high rates of erroneous benefits rather than by cutting recipient benefits. Sanctions of $233 million for erroneous payments prior to fiscal year 1988 were to be assumed as collected in 1988. Legislation also was recommended to increase sanctions imposed for errors in fiscal year 1988 and beyond, allowing the Federal Government to collect these sanctions in advance, based on estimated State error rates. This was projected to reduce appropriations by another $258 million.

Additional savings were to come from reducing by $67 million food stamp benefits to households participating in the Low Income Home Energy Assistance and the Job Training Partnership Act programs, holding Puerto Rico's block grant to $825 million rather than $879.75 million and saving $5 million through rules changes for Federal cost-sharing of State and local administrative expenses.

(1) Low-Income Home Energy Assistance Act Recipients

For many persons who receive both Low Income Home Energy Assistance Program (LIHEAP) benefits and food stamps, the administration proposal advanced in both 1986 and 1987 would have counted more of their income for food stamp eligibility, resulting in reduced food stamp benefits or elimination from food stamp eligibility. This would have affected more than half of low-income persons participating in the LIHEAP and resulted in savings of almost $57 million.

LIHEAP benefits always have been excluded as income in the Food Stamp Program, so they do not directly affect food stamp benefits or eligibility. As part of legislation reauthorizing LIHEAP in 1986 (Public Law 99–425), the Food Stamp Program cannot count LIHEAP benefits in determining eligibility or benefits. This means that a household may not count its LIHEAP benefits as income and it requires recipients to claim utility bills covered by LIHEAP benefits as deductible shelter expenses.

The administration views allowing LIHEAP recipients to claim utility bills as a shelter expense as a double benefit which they feel is unfair to those who pay their utility bills from other income. The administration's proposal would allow LIHEAP recipients to claim as a shelter expense deduction only the part of their utility bills they pay themselves, while LIHEAP benefits would continue to be excluded as income.

Proponents of the current law argue that the administration proposal would dilute the value of LIHEAP benefits which face appropriation budget cuts and are estimated to reach less than 30 percent of income-eligible households.

(2) Job Training Partnership Act Recipients

The administration proposed in 1985, 1986, and 1987 to increase the amount of income that Job Training Partnership Act (JTPA) participants counted for food stamp eligibility. Such a move would reduce food stamp benefits and make fewer people eligible while saving an estimated $10 million in benefit costs in 1988.

The Food Security Act required that earnings received by on-the-job trainees in JTPA programs be counted as earned income for food stamp purposes, except for dependents under age 19. The administration's proposal would also count all other income received by JTPA participants, such as stipends and incentive allowances.

(3) Puerto Rico

In 1982, Congress changed the Puerto Rico Food Stamp Program to a block grant, through which it was given an annual Federal grant to operate its own program, which serves approximately 1.6

million persons. The original amount appropriated was $825 million, much less than if the regular Food Stamp Program had been continued. The $825 million level continued until the 1985 Food Security Act set higher levels, increasing in increments to $936.75 million in 1990. The administration requested only $825 million for the program in fiscal year 1988.

(4) State Administrative Funding

Two changes were proposed for the fiscal year 1988 budget to reduce the Federal 50-percent cost sharing for State administrative expenses. States with average administrative expenses in excess of 125 percent of the national average would receive only a 25-percent Federal match for their administrative expenses above the 125 percent threshold and no Federal assistance for administrative expenses above 150 percent of the national average. Also, matching rates for computerization and antifraud efforts gradually would be reduced from 75 percent to 50 percent beginning in fiscal year 1988. This was estimated to save $5 million in fiscal year 1988 and more in later years.

C. LEGISLATION

1. Fiscal Year 1988 Appropriations

Under the law, continuing appropriations for fiscal year 1988, (Public Law 100–202), $13.5 billion was appropriated for the Food Stamp Program, including $879 million in nutrition assistance for Puerto Rico. The House Committee on Appropriations version of the fiscal year 1988 appropriations for the Agriculture Department included $12.9 billion for food stamps (H.R. 3520). The Senate Appropriations Committee, in its version of the fiscal year 1988 Agriculture appropriations measure, included $13.7 billion for the Food Stamp Program. Spending for food stamp benefits and the Federal share of the State administrative costs is protected from sequestration under the Gramm-Rudman-Hollings deficit-reduction bill and was not an issue in discussions on budget reduction alternatives.

The appropriation figure was at the upper end, closer to the Senate committee's recommendation. This was attributed to the increase in the cost of the Thrifty Food Plan, liberalizations of the homeless legislation, and the inability to collect fiscal sanctions from the States. Since January 1987, higher-than-expected food price inflation had influenced both the Congressional Budget Office and the administration to project higher cost estimates for fiscal year 1988. Food stamp participation and benefits costs also are affected by wage and unemployment levels.

The conferees also directed the Secretary of Agriculture to enact new regulations for improving the food stamp quality control system to be in place before the beginning of fiscal year 1989.

2. Omnibus Homeless Relief Legislation

Congressional action on food stamps in 1987 began with amendments enacted into law (Public Law 100–77) as part of the Stewart B. McKinney Homeless Assistance Act. Food stamp provisions of both House and Senate bills were included with an expected cost of

$54 million in fiscal year 1988 and $65 to $69 million annually in subsequent years. Although the homeless are eligible for food stamps, the law incorporated these particular provisions intended to address specific food stamp problems related to homelessness.

The new law would increase benefits to those with high shelter costs by increasing the shelter deduction to $164 a month, from $152 a month for new applicants and current recipients as they become recertified for eligibility. The Senate's recommendations for revising procedures to calculate future inflation adjustments for the shelter deduction ceiling and the standard deduction were also included.

From both the House and Senate versions, the measure authorizes States to inform the homeless about food stamps through outreach activities with 50 percent Federal cost sharing. The Food Stamp Act was amended in 1981 to remove outreach programs as a required State activity with Federal cost sharing.

House provisions which increased benefits to certain homeless persons living in welfare hotels were included as were measures to achieve cost savings by delaying income eligibility guideline adjustments and increasing penalties for fraud.

Also included from the Senate proposals were amendments to increase benefits by allowing parents of minor children (together with their children) to apply for food stamps separately from any relatives they live with and to require expedited service for the homeless and those with very high shelter costs.

3. WELFARE REFORM

The Food Stamp Family Welfare Reform Act of 1987 (H.R. 3337), was reported out of the House Committee on Agriculture on October 26, 1987. Its purpose is to change the Food Stamp Program to complement the proposed revisions in the welfare system of the Family Welfare Reform Act (H.R. 1720). The two bills were merged when H.R. 1720 passed the House of Representatives on December 16, 1987. The Congressional Budget Office (CBO) estimates the cost of the provisions of H.R. 3337 as $11 million for fiscal year 1988 and $145 to $166 million in later years.

Four areas of modification of food stamp law were proposed. To better coordinate with other Federal laws and programs which affect individuals receiving food stamps, the bill would:

(1) Make permanent the automatic eligibility for food stamps for AFDC and SSI recipients,

(2) Require that income received as advance payments of earned income tax credits be disregarded in food stamp eligibility,

(3) Require further coordination in concurrent application procedures for AFDC and food stamps, and

(4) Require that the first $50 a month of a family's child support payments be disregarded in eligibility and benefit determination.

Proposed changes in work, training, and education incentives include increasing the degree of dependent care costs related to work for determining food stamp eligibility and benefits, treating education assistance the same way for all assistance programs, and opening food stamp eligibility to certain low-income postsecondary students. Food stamp employment and training programs would be assisted by allowing States to increase payments for support services with 50 percent Federal cost sharing.

Demonstration projects would be allowed for up to 10 States to test changing welfare program rules to better address the problems of poverty and assisting families and individuals to become self-sufficient. It also would allow Washington State to implement its "Family Independence Program." Food stamp rules affecting potentially eligible farmers also would be liberalized in relation to crop payments as income, irregular income, and farm property. Outreach programs to farm households with 50 percent Federal matching funds also would be authorized.

4. Other Legislation

Measures to place a moratorium on the collection of food stamp sanctions through September 1988 (S. 1440 and H.R. 3160), were introduced in the 100th Congress to delay or modify penalties on the States until after corrective action could be taken on the food stamp quality control system. An amendment to accomplish the moratorium was adopted by the Senate during consideration of H.J. Res. 395 to continue appropriations for fiscal year 1988. However, the amendment was deleted in conference. Instead, substitute language of intent was included by the conferees in the continuing resolution for fiscal year 1988 appropriations which requires the Department of Agriculture to have in place new regulations for improving the food stamp quality control system before fiscal year 1989.

It was noted that the current food stamp quality control system does not accurately measure State administrative performance according to statistically acceptable criteria and directed the Secretary to take into consideration the recommendations of the National Academy of Sciences and other outside groups in reviewing and reforming the method for determining State error rates.

Amendments to the Older Americans Act reauthorization passed by Congress in 1987 (Public Law 100-175) also contained a food stamp-related initiative. Programs would be authorized under the Act to expand outreach services to older persons who may be eligible for, but who are not receiving, benefits under the SSI, Medicaid, and Food Stamp Programs. There would be authorized $10 million for each of fiscal years 1989 and 1990 for grants to States to inform individuals about their potential eligibility and to help them apply for assistance.

D. REGULATORY AND JUDICIAL ACTION

Minimal regulatory and judicial action occurred on the Food Stamps Program in 1987. The administration proposed changes in regulations to enhance consistency with the Aid to Families with Dependent Children (AFDC) program. Many felt the proposed regulations would remove a number of basic procedural protections from food stamp applicants and recipients and would make it even more difficult for those in need to apply. Under the proposed regulations, States would be allowed to:

(1) Immediately deny a household if a person missed an interview with no chance to reschedule a second interview. Households would have to reapply after a missed interview,

(2) Deny applications if all information is not gathered within 30 days,

(3) Eliminate information in notices to applicants such as the food stamp office's phone number, name of contact person, and the availability of legal aid, and

(4) Count burial arrangements in excess of $1,500 as resources.

Considerable congressional and public opposition has been raised against these proposals and it is doubtful they will be implemented as originally proposed.

A U.S. Supreme Court decision was expected in 1988 in the case of *United Auto Workers and United Mine Workers* v. *Lyng*. This case challenges the food stamp rule that renders an entire household ineligible for food stamps if the household contains a member who is on strike. USDA has challenged a lower court decision which held in favor of the unions. The constitutional issues concern denying strikers equal protection under U.S. labor law as this rule lays a heavier penalty than other food stamp rules on those who don't fulfill work rules because it penalizes the entire household rather than the individual. The Congress and labor lawyers throughout the Nation will continue to closely follow this case and related issues.

E. PROGNOSIS

During the first session of the 100th Congress, attention was focused on liberalizing the rules of the Food Stamp Program, and administration initiatives for cut-backs were not taken up. In 1988, congressional concern with food stamps most likely is to be centered on revisions to the food stamp "quality control" system (and the associated financial penalties on States) and the relationship between food stamps and welfare reform as the Senate takes up the House-passed measure.

Chapter 8

HEALTH CARE

OVERVIEW

Catastrophic health care emerged as the health policy "buzz" phrase in the Senate and the House during the first session of the 100th Congress. Legislation to begin to protect Medicare beneficiaries from the costs of catastrophic illnesses started out on a fast track and many health care and aging advocates felt a final bill could be signed into law prior to the August recess. However, the bill was derailed in the Senate due to general concerns about the costs of the new benefits and specific concerns about the costs of including a prescription drug benefit within the legislation.

The Senate finally passed its version of the catastrophic bill in late October, but the bill was sent to a joint Senate/House conference to work out the differences between the versions. (The conference committee was expected to complete its work on this legislation in the second session of the 100th Congress.)

During debate on arguably the largest overhaul of the Medicare Program since its enactment in 1965, one of the greatest challenges to Congress in 1987 continued to be the need to rein in health care costs to help reduce substantial Federal deficits while assuring older Americans access to affordable, high quality health care. The deficit reduction pressures played the central role in assuring that the catastrophic health care legislation had to be self-financed by Medicare beneficiaries to obtain enough support to ensure its passage. Similarly, every other health issue affecting the elderly continued to be framed in terms of its effects on the Federal budget. As in recent years, the Congress continued its practice of passing very few freestanding health care bills and most of the major congressional health agenda (beyond the catastrophic health care bill and the Medicare and Medicaid Patient Program Protection Act) was dealt with through the annual budget reconciliation and appropriations processes.

Almost overshadowed by developments in the catastrophic legislation and cuts in the Medicare Program aimed at reducing the Federal deficit was the Health Care Financing Administration's announcement that Part B premiums would be raised by an unprecedented 38.5 percent in 1988. Despite a flurry of activity (including a Senate Special Committee on Aging hearing and an unsuccessful attempt by Chairman John Melcher to amend the budget reconciliation bill to reduce the premium increase), most Members of Congress accepted the increase as as "fait accompli." As an alternative, the Congress developed legislation to control future Part B expenditures.

Other important health issues raised during the first session of the 100th Congress included equalizing payments to rural health care providers, expanding and clarifying home health benefits, addressing concerns related to operating practices of health maintenance organizations (HMO's), attempting to assure the future stability of employer-provided retiree health benefits, and increasing the Federal Government's commitment to geriatric research and training.

A. MEDICARE

1. Background

(A) HEALTH CARE COSTS

Prior to the mid-1970's, cost of care was not a major issue among health specialists. Instead, expansion of access and the improvement of quality of care were foremost on the Nation's health policy agenda. As costs began to skyrocket, however, policymakers began to realize that controlling these increases had to become a priority, and much more attention was focused on the type of "bang" the Nation was getting for its bucks. Between 1965 and 1986, national health expenditures increased from nearly $41.9 billion (5.9 percent of the gross national product) to $458.2 billion (10.9 percent of GNP).[1] (See chart 1.) Even given today's apparent slower rate of increase, health care expenditures are expected to reach $647.3 billion (12 percent of GNP) by 1990, and $1.53 trillion (15 percent of GNP) by the year 2000. (See chart 2.)

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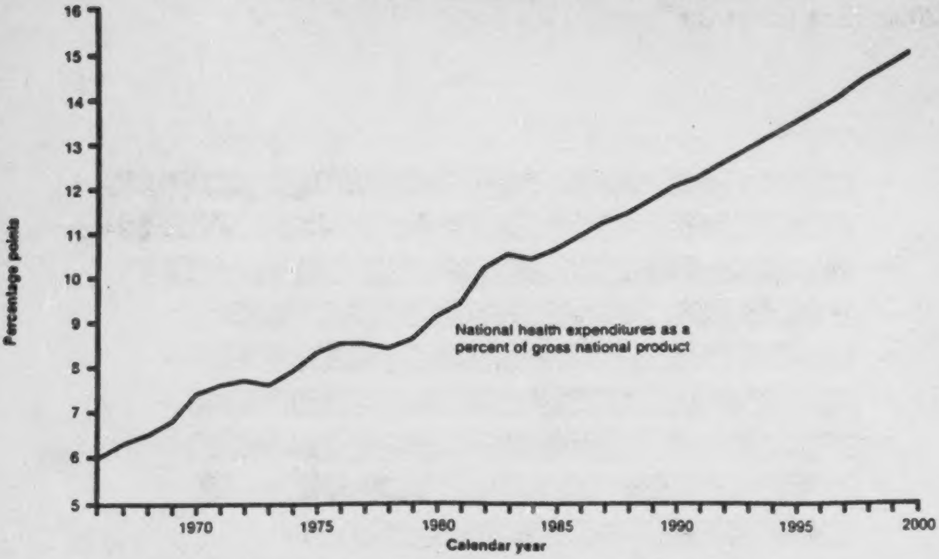
[1] U.S. Department of Health and Human Services. Office of the Actuary, Medical Care Costs, 1985. Washington, 1986.

CHART 1

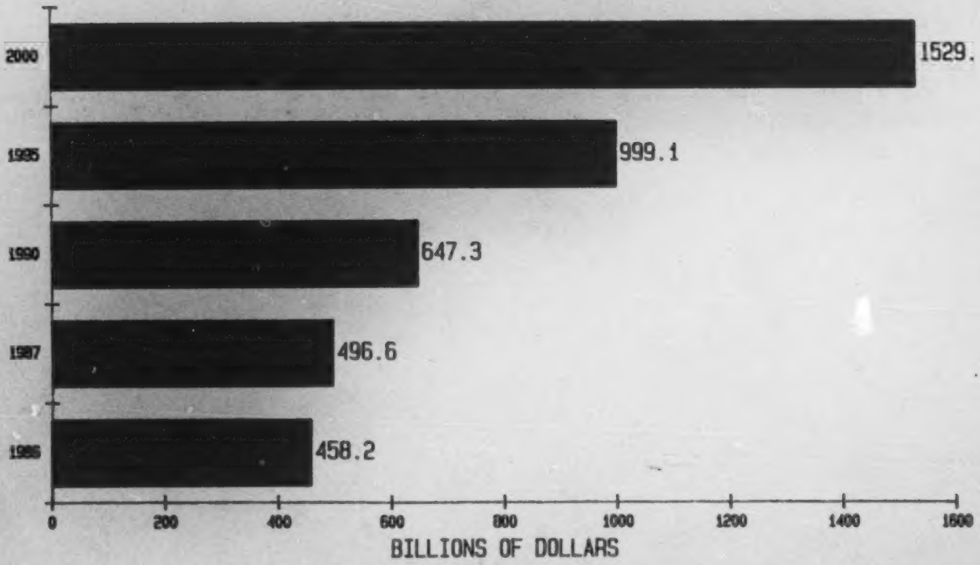
Percent change in national health expenditures as a percent of gross national product: Calendar years 1966-86 and projections 1987-2000



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

CHART 2

NATIONAL HEALTH SPENDING
1986-2000

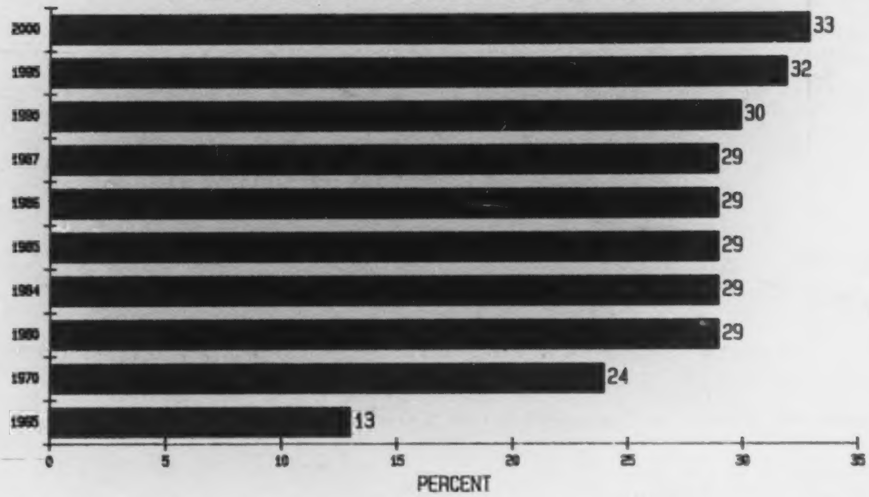


Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

The role of the Federal Government as a payer for health services has grown along with the overall increases in health care costs. In 1965, the Federal Government paid $5.5 billion (13.2 percent of the Nation's health bill compared with $134.7 billion (29.4 percent) of national health expenditures in 1986. The Federal Government's share of the national health bill is projected to rise to $195.5 billion (30.2 percent) in 1990, $498.6 billion (33 percent) by 2000. (See chart 3.)

CHART 3

FEDERAL SPENDING ON THE NATION'S HEALTH
AS A PERCENT OF ALL FEDERAL SPENDING: 1965-2000

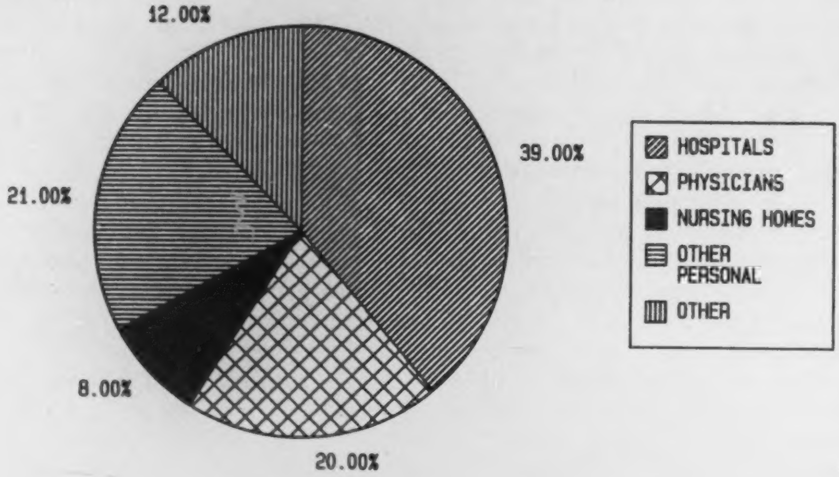


Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

Hospital care costs continue to be the largest component of the Nation's health care bill. In 1987, 39 percent ($192.6 billion) of the $438.9 billion spent on personal health care was paid to hospitals. During the same year, physicians were paid $101.4 billion or 20 percent of total expenditures for health care. (See chart 4.)

CHART 4

WHERE OUR HEALTH DOLLAR WENT IN 1987



Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

Throughout the last two decades, the structure and delivery of health care have been plagued by perverse incentives, resulting in the overutilization of services, inefficiency, and waste. Led by the Federal Government, which faced major funding increases each year to pay for Medicare, Medicaid, and other health programs, third-party payers began to question whether large scale reform of health care was needed. In 1983, Congress and the administration created the prospective payment system for Medicare reimbursement of hospitals, at the time the most dramatic change in Medicare since its enactment.

Prospective payment system.—The Medicare prospective payment system (PPS) pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of 473 diagnosis related groups (DRG's) to categorize patients for reimbursement. The amount a hospital receives from Medicare no longer depends on the amount or type of services delivered to the patient, so there no longer are incentives to overuse services. If a hospital can treat a patient for less than the DRG amount, it can keep the savings. It the treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment.

Since the 1983 Medicare PPS reform, States have moved to adopt prospective payment methodologies for their Medicaid programs. Private payers, too, are supporting a hybrid of reimbursement reforms, ranging from prospective rate setting to innovative capitation schemes. The health care arena is changing so rapidly on so many fronts that any broad characterization of it today is likely to be outdated tomorrow. Nevertheless, it seems fair to say that the overriding concern influencing the Nation's health care system is cost containment.

Trends in health care inflation.—Looked at in terms of nominal dollars (dollars not adjusted for inflation) the Nation's cost containment efforts seem to be working. In 1986, the total health care expenditures rose 8.4 percent to $458.2 billion from $422.6 billion in 1985, in nominal dollars.[2] This was the lowest annual increase in the past 20 years, dropping below the 10 percent rate of growth achieved during the economic stabilization program in 1973 when some price increases were constrained artificially.

Most analysts attribute the slowdown in the growth of health care costs to a number of factors—not simply cost containment measures alone. According to DHHS, the slowdown also has resulted from a low rate of inflation in the economy and changing patterns of demand for services, in particular a decline in the use of hospital inpatient services.

The optimistic reports on cost containment efforts aside, however, it may be possible that health care expenditures actually may be escalating faster than in the 1970's. According to Uwe Reinhardt, one of the Nation's leading health economists, Americans have been fooled into thinking that cost hikes are moderating. Reinhardt points to the fact that, "relative to the overall consumer price index, the prices of health services rose much more rapidly after 1980 than they did in the late 1970's." [3]

Even more disturbing than the possibility that we have not yet harnessed spiraling health care costs is the fear that existing cost containment initiatives may be exacting a toll in other parts of the health care delivery system. Pressures to reduce costs and make health care delivery more efficient may actually reduce access to and diminish the quality of health care.

This country may, in fact, be faced with a difficult tradeoff. Given an economy struggling under huge budget deficits, the goals of "unlimited access" and "highest possible quality" are becoming more difficult to achieve. This presents Americans with the dilemma of deciding how, in a period of limited national resources, to assure access to the health care system while preserving its quality.

(B) HEALTH CARE UTILIZATION

Americans of all ages are healthier today than they were 10-20 years ago. While most older people report themselves to be in good to excellent health, many tend not to report specific health problems and mistakenly think they are caused by old age rather than disease. Yet age does affect a person's health, particularly the way the body reacts to disease and drugs.

Individual assessment of a person's own health is often the most important measure of health status and affects an individual's use of health services. Women over 65 tend to report better health than do men in the same age group.

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[2] "Natonal Health Expenditures, 1986-2000, by the Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, Health Care Financing Review, Summer 1987, vol. 8, no. 4, p. 24.

[3] Uwe Reinhardt, How "Money Illusion" May Have Saved the American Health Sector from Starvation (so far), 1986.

Chronic diseases are a major threat to the independence of older persons. Arthritis, hypertension, heart conditions, and hearing disorders are leading chronic conditions among the noninstitutionalized elderly. Hospitalization of most older persons is caused by an acute episode of a chronic illness. Visits to the doctor also are most often for treatment of chronic conditions.

The dimensions of the current health services use by the elderly only hint at future needs. Health services usage by the elderly is growing because of absolute increases in the total aged population, greater numbers of individuals in the eldest subgroup, and an increased number of services provided per person. Greater expectation of good health, the availability of third-party financing and increased access to medical advances such as renal dialysis and radiation therapy also are leading reasons for greater use of health services by the elderly.

(1) Hospital Utilization

Short hospital stays by the elderly increased by more than 57 percent between 1965 and 1985. Since 1985, admissions for elderly patients have decreased. In 1985, a survey of non-Federal short-stay hospitals revealed that 10.5 million elderly patients were discharged from hospitals, 30 percent of all patient stays. Those 75 and older accounted for 15.7 percent of short stays. According to the American Hospital Association national hospital survey, the average length of stay for elderly patients has declined, from 10.8 days in 1977 to 8.9 days in 1987.

Older persons tend to remain in the hospital longer than the general population. The hospital discharge rate for those 85 and older was 91 percent higher than that for the 65–74 age group. The average hospital stay for persons 65–74 was about 8.5 days in 1985 compared with 10 days for the 85 and older group.

(2) Use of Physicians' Services

Utilization of physicians' services increases with age. Approximately four out of five elderly living in the community had at least one contact with a physician in 1986. On average, the elderly are more likely than younger persons to make frequent visits to a physician. Persons 65 and older visit a physician six times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and older reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[4]

Approximately three-quarters of physician visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, outpatient offices, and home and telephone consultations.

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[4] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, D.C., U.S. Govt. Print. Off., 1987–88 edition, p. 117.

The aging of the population will increase the demand for physician care. Projections show that demand will increase by 22 percent from 250 million physician contacts to 305 million contacts by the year 2000 and by 125 percent (more than 562 million visits) by 2030.[5]

Because chronic conditions are likely to increase with age, the health care needs of the elderly are broad in scope and require the participation of a number of health care professionals who specialize in geriatrics and gerontology. In addition, nurses have substantial responsibilities for providing services to the elderly in a wide range of settings such as hospitals, long-term care settings, ambulatory care programs and day care programs. Dentists, social workers, and allied health care professionals also can actively contribute to the care of the elderly when they understand the needs of older patients. Available data, however, indicate that only a small fraction of professional health care schools have programs in geriatrics and gerontology.

(3) Use of Home Health Services

Home health care has been one of the most rapidly growing Medicare benefits. There has been rapid growth in the number of participating agencies (from 3,000 in 1981 to more than 5,900 currently) as well as the volume of visits and services provided. Growth has begun to level off as a result of efforts by the Health Care Financing Administration to curtail growth. (See table 1.)

TABLE 1.—MEDICARE HOME HEALTH SERVICES

Year	Persons served (thousands)	Number of persons served per 1,000 enrollees	Total reimbursements (millions of dollars)	Total visits (millions)	Number of visits per 1,000 enrollees
1975	500	22	215	11	431
1980	957	34	662	22	788
1983	1,351	45	1,398	37	1,227
1984	1,516	50	1,666	40	1,324
1985	1,587	51	1,754	39	1,266

Source: Health Care Financing Administration.

The increase in home health utilization stems in part from legislative changes adopted in 1980 which removed certain payment, coverage, and participation restrictions from the home health benefit. Additionally, implementation of the prospective payment system in 1983, with its incentives for more efficient management of health care resources, resulted in a significant drop in hospital lengths of stay and prompted a transfer of care from inpatient hospital settings to a variety of outpatient settings, including home health agencies.

The increasing lifespan, the aging of the elderly population, and the continuing advances in medical technology all point to the conclusion that more elderly Americans will suffer chronic conditions that limit their daily activities. Older Americans with chronic conditions will require extensive health care services, including home health care. Currently, Medicare beneficiaries over 85 are nearly five times more likely to receive home care services than Medicare beneficiaries aged 65–69. As the "old-old" population (those older than 85) increases, home care demand and utilization also will increase significantly. (See chart 5.)

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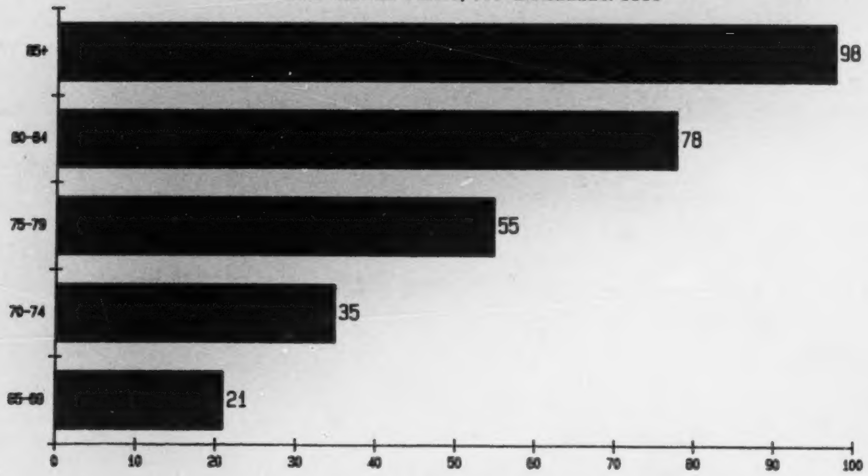
[5] Ibid.

CHART 5

USE OF HOME HEALTH SERVICES
PERSONS SERVED PER 1,000 ENROLLEES: 1983



Source: Marian Gornick et. al., "Twenty Years of Medicare and Medicaid," Health Care Financing Review, Annual Supplement

(4) Use of Disease Prevention Services

Utilization of disease-prevention services by the elderly varies by type of service. For example, elderly persons visit dentists less often than the younger population. In 1986, only 43 percent of those over 65 used dental care, while 59 percent of the general population did. Presently, older persons do not receive sufficient preventive or therapeutic dental care. It is estimated that almost one-third of the population is likely to lose some or all of their teeth between the ages of 50 and 70, primarily because of periodontal disease.

In contrast to the low incidence of dental care, 41 percent of the elderly in 1979–80 had one or more eye-care visits compared with 24 percent of those under 65. This percentage almost certainly would be higher if Medicare covered optical services and products.[6]

Many of the chronic conditions of the elderly are strongly associated with personal health habits. In general, the evidence linking changes in health habits by older persons to reduced risk of disease is fragmentary. The most dramatic example of a behavior change that produces positive effects on health is cessation of cigarette smoking, which is a major risk in cardiovascular diseases and selected cancers. When a person of any age stops smoking, the benefits to the heart and the circulatory system begin right away. The risk of heart attack and stroke drops and circulation to the hands and feet improves. Nonsmokers also have a lower risk of contracting influenza and pneumonia which sometimes can be life-threatening diseases for older persons.

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[6] Ibid., p. 123.

(5) Health Care Expenditures of the Elderly

Persons 65 and older, 12 percent of the population, account for a third of the Nation's total personal health care expenditures. These expenditures represent total health care investment from all sources exclusive of research. In 1984 (the latest data currently available), total personal health care expenditures for the elderly were $120 billion (tables 2 and 3) and per capita spending reached $4,200. That represented a 13-percent average annual growth rate since 1977. It is particularly notable that older Americans spend as large a percentage of their income on health care needs (15 percent) as they did prior to the existence of Medicare.

TABLE 2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

Year and source of funds	Type of service: Total care	Hospital	Physician	Nursing home	Other care
1984:					
Total per capita	100.00	100.00	100.00	100.00	100.00
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	.4	0.4	.0	.7	.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	1.5	11.4
Other government	5.6	9.1	.7	4.4	3.4

TABLE 3.—DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY TYPE OF SERVICE AND SOURCE OF FUNDS: UNITED STATES, 1984

Year and source of funds	Total per capita	Type of service: Total care	Hospital	Physician	Nursing home	Other care
1984:						
Total per capita	$4,202	100.00	45.2	20.7	20.9	13.2
Private	1,379	100.0	15.7	25.0	33.1	26.2
Consumer	1,363	100.0	15.3	25.3	33.1	26.3
Out-of-pocket	1,059	100.0	5.6	21.4	41.6	31.3
Insurance	304	100.0	49.2	38.6	3.3	8.9
Other private	16	100.0	42.1	1.9	39.1	17.0
Government	2,823	100.0	59.7	18.6	15.0	6.8
Medicare	2,051	100.0	69.2	24.5	.9	5.4
Medicaid	536	100.0	17.0	3.1	68.1	11.8

TABLE 3.—DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY TYPE OF SERVICE AND SOURCE OF FUNDS: UNITED STATES, 1984—Continued

Year and source of funds	Total per capita	Type of service				
		Total care	Hospital	Physician	Nursing home	Other care
Other Government	23.6	100.0	73.2	2.4	16.5	7.9

Source: Waldo, Daniel R., Lazenby, Helen C: Demographic Characteristics and Health Care Use and Expenditures by the Aged in United States: 1977–84, "Health Care Financial Review," vol. 6, No. 1, fall 1984.

(6) Health Care Expenditures by Source

(a) Hospital

Hospital care for the aged was projected to cost $54 billion in 1984; this is an amount equal to $1,900 per capita. Medicare will reimburse about 74 percent of that total while other public funds will pay about 15 percent of the bill. Private health insurance will cover 8 percent of the costs and the remaining 3 percent will be paid out-of-pocket.[7]

(b) Physicians' services

Spending for physician services to the elderly grew an average of 18 percent per year from 1977 to 1984, reaching a projected level of $24.8 billion for 1984.[8] The growth in patient days spent in the hospital by the elderly (3 percent increase per year during the period 1977–83) largely accounts for the increase in physician services and costs. The growth in patient days spent in the hospital by the elderly (3-percent increase per year during the period 1977–83) largely accounts for the increase in physician services and costs during that period. More recent increases may be partly attributable to substitutions of ambulatory services for inpatient care. Some people also speculate that physicians have increased the number of services they provide to make up for limitations on Medicare payment increases.[9]

(c) Home health services

As a percentage of total Medicare expenditures, the amount of reimbursement for home health care has been small. According to the Health Care Financing Administration, Medicare payments for home health care comprise a relatively small 3.8 percent of total program outlays. For calendar year 1987, total reimbursements for Medicare home health services were projected to $2.9 billion. Chart 6 indicates however, that Medicare's home health benefit expenditures are one of the fastest growing components of the Medicare Program.

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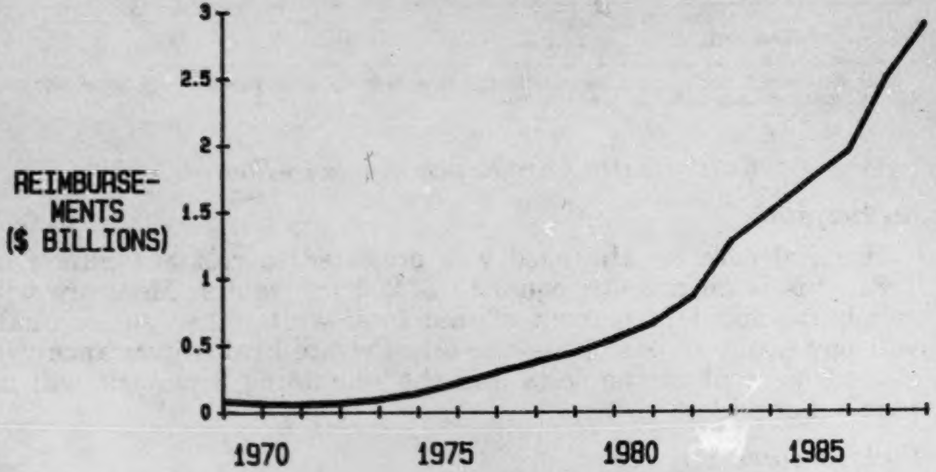
[7] Waldo, Daniel R. and Helen C. Lazenby. Demographic Characteristics and Health Care Expenditures by the Aged in the United States: 1977–1984. Health Care Financing Review. Vol. 6, No. 1, Fall, 1984, p. 12.

[8] Ibid., p. 13.

[9] Ibid.

CHART 6

MEDICARE HOME HEALTH REIMBURSEMENTS
1969-1987



Source: HCFA/Bureau of Data Management
and Statistics

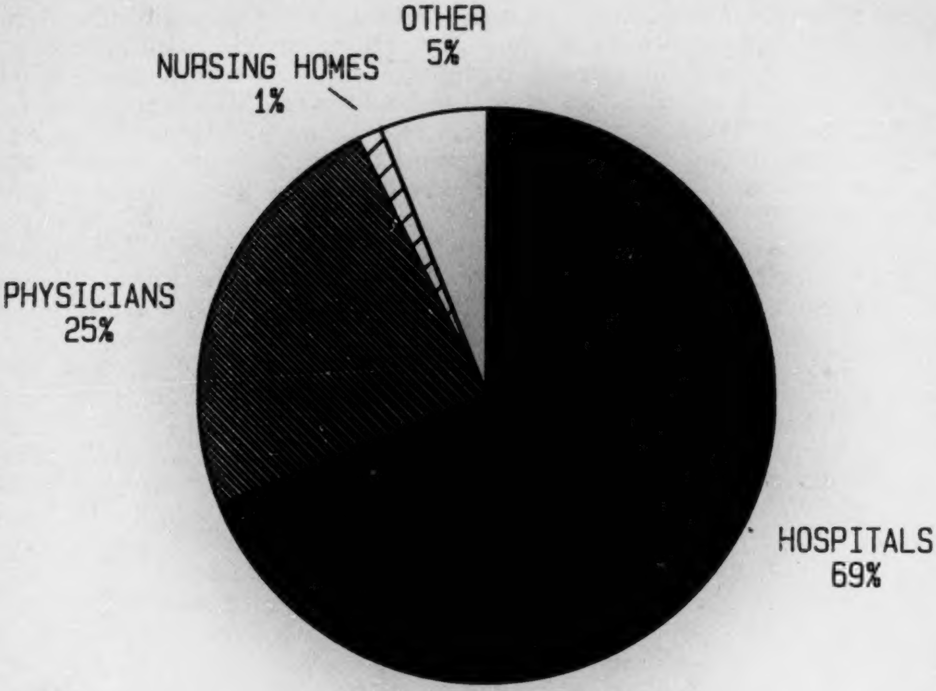
(C) MEDICARE PROGRAM DESCRIPTION

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In 1987, Medicare insured 29 million aged and 3 million disabled individuals. At a fiscal year 1987 estimated cost of $79.5 billion, Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

As insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services (see chart 7). Medicare does not cover the hospital costs of extended acute illnesses, however, and does not protect beneficiaries against potentially large co-payments or charges above the Medicare payment rate for physician services. These shortcomings in Medicare's coverage of acute illness costs have led two-thirds of older Americans to purchase supplemental private coverage, often referred to as medigap coverage.

CHART 7

WHERE THE MEDICARE DOLLAR GOES: 1985



SOURCE: Health Care Financing Administration,
Office of Financial and Actuarial Analysis

Medicare (authorized under title XVIII of the Social Security Act) provides health insurance protection to most individuals 65 and older, to persons who have been entitled to Social Security or railroad retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the Hospital Insurance (HI) Program (Part A), and the Supplementary Medical Insurance (SMI) Program (Part B).

(1) Hospital Insurance Program (Part A)

Part A of Medicare is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During 1987, each worker and employer paid a tax of 1.45 percent on the first $43,800 of covered employment earnings. The self-employed pays both the employer and employee shares. In 1988, each worker and employer will pay 1.45 percent on the first $45,000 of covered earnings.

In 1986, payroll taxes for the HI Trust Fund (HI) amounted to $54.6 billion, accounting for 92.1 percent of all HI income. Interest payments equaled 6.5 percent of all HI income while the remaining 1.8 percent consisted primarily of transfers from the Railroad Retirement Account and the general fund along with premiums paid by voluntary enrollees. Of the $50.4 billion in HI disbursements, $49.8 billion was for benefit payments while the remaining $700 million (1.3 percent) was spent for administrative expenses. In 1986, the HI Trust Fund was credited with an additional $10.6 billion, representing a partial repayment of the interfund loan made to the Federal Old-Age and Survivors Insurance Trust Fund in December 1982.[10]

During each benefit period (which begins when an insured person enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for 60 days), Part A pays for:

(1) Ninety days of inpatient hospital care, subject to a deductible ($520 in calendar year 1987, $540 in calendar year 1988), and a daily copayment ($130 in 1987, $135 in 1988) that is required for the 61st day through 90th day. An additional lifetime reserve of 60 days, subject to a daily copayment ($260 in 1987, $270 in 1988) may be drawn on when an individual exceeds 90 days in a benefit period. Both the deductible and copayment are adjusted annually;

(2) One hundred days of post-hospital skilled nursing facility (SNF) care, subject to a daily copayment ($65 in 1987, $67.50 in 1988) after the first 20 days;

(3) Home health care on a part-time or intermittent basis. There is no specified limit on the number of visits and no copayment is required; and

(4) Hospice services for the terminally ill. A beneficiary may elect to receive services for two 90-day periods and one subsequent 30-day period during his or her lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. This election may be revoked.

Hospital reimbursement under Medicare has been phased in from the original retrospective cost-based reimbursement method of payment to a system of prospective payments (PPS) based on diagnosis related groups (DRG's). Under PPS, hospitals are paid a set price for each case that fits into one of 473 DRG's. The phase-in of payments by DRG rates began in 1983 and it was completed in 1987.

(2) Supplementary Medical Insurance (Part B)

Part B of Medicare, also called supplementary medical insurance, is a voluntary program financed jointly through monthly premium charges ($17.90 in 1987 and $24.80 in 1988) on enrollees and

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[10] U.S. Department of Health and Human Services, Health Care Financing Administration. 1987 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund. Washington, March 30, 1987, p. 2.

Federal general revenues. Under current law, premiums cover 25 percent of program costs; 75 percent are funded from general revenues. Part B (with certain exceptions) pays 80 percent of reasonable charges for the following covered services after the insured meets a $75 deductible: Physician and other professional services, diagnostic tests, medical devices, outpatient hospital services, and laboratory services.

In 1986, approximately 30.5 million people were covered under Part B. General revenue contributions totaled $17.8 billion, accounting for 72.2 percent of all income. Another 23.2 percent of all income resulted from premiums paid by participants, with interest payments accounting for the remaining 4.6 percent. Of the $27.3 billion in disbursements, $26.2 billion (96.1 percent) was for benefit payments while the remaining $1.1 billion (3.9 percent) was for administrative expenses.[11]

Physician reimbursement.—Medicare pays physicians the "reasonable" or "approved" charge rate for their services, less the deductible and the copayment. The reasonable charge levels for a service have been determined through a method referred to as customary, prevailing, and reasonable (CPR). Under CPR, payment for each service is limited to the lowest of: (1) The physician's actual bill for the service; (2) the physician's customary charge for the service, or (3) the prevailing charge for the service in that community. (The prevailing charge is adjusted by the Medicare economic index.) To control ever-increasing Part B program expenditures and to provide beneficiaries with the opportunity to select a physician who has agreed to accept Medicare's "assigned" rate, the Deficit Reduction Act of 1984 (DEFRA, Public Law 98-369), established the concept of the participating physician. A participating physician voluntarily enters into an agreement with the Secretary of the Department of Health and Human Services to accept assignment (Medicare's allowable reimbursement rate) for all services provided to all Medicare patients for a 12-month period. If assignment is accepted, beneficiaries are not liable for any out-of pocket costs other than the standard deductible and coinsurance payments.

A number of incentives have been implemented to encourage physicians to sign participation agreements. These include higher prevailing charge screens, more rapid claims payment, and widespread distribution of participating physician directories. As of January 1987, 30.6 percent of doctors were participating physicians.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the actual charges of nonparticipating physicians are limited during a 4-year period beginning on January 1, 1987. Under the maximum allowable actual charge (MAAC) limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge are limited to a 1 percent annual increase in their actual charges. Nonparticipating physicians with lower actual charges may increase their charges at a more rapid rate.

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[11] *Ibid.*

(3) Peer Review Organizations

Hospitals are required to enter into agreements with peer review organizations (PRO's) as a condition for receiving payments under Medicare's PPS for inpatient hospital services. PRO's review the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care.

The Secretary of the Department of Health and Human Services (DHHS) is required to contract with PRO's. Organizations eligible for PRO contracts include physician-sponsored organizations, physician-access organizations, and health benefit payer organizations. PRO's are expected to serve the dual role of curtailing unnecessary costs and assuring the quality of health care. However, in recent years, Aging Committee investigations have found that PRO's primary emphasis has been on controlling costs, rather than on assuring quality care.

DHHS contracts out to 54 PRO's. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands are designated as separate PRO areas. Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands are considered to be in a single PRO area.

The PRO review process begins after a Medicare beneficiary is discharged from the hospital and payment is made. Paid bill data is sent to the PRO, which selects a sample for review and requests the relevant medical records from the hospital. PRO reviewers (usually nurses) use criteria which contain the generally recognized reasons justifying a patient's hospital admission or surgical procedure. If the PRO reviewer determines that the care was not medically necessary or that it should have been provided in another setting (e.g., an outpatient facility), the PRO will issue a payment denial. A payment denial can only be made after the attending physician has been given an opportunity to discuss the case with a PRO physician. During fiscal year 1986, PRO's denied payment for 8,785 cases on the basis of inappropriate admissions and transfers.

(4) The Health Maintenance Organization Benefit

During 1982 and 1983, DHHS awarded 26 Medicare demonstration program contracts to develop Medicare Health Maintenance Organizations (HMO's). These demonstration projects, which were operational in 21 cities across the country, were implemented to test whether the HMO concept would be effective in holding down Medicare expenditures. HCFA initiated a nationwide program in 1985 providing for the expanded use of HMO's by Medicare.

Two kinds of organizations are eligible to contract with Medicare: Federally qualified HMO's under the 1973 HMO Act and competitive medical plans (CMP's) as defined in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). CMP's include any organization which provides a minimum range of Medicare services through physicians who are employers, partners, or contractors. This category was created to broaden participation and stimulate competition in the medical marketplace.

Under TEFRA, Medicare pays participating organizations for services rendered. HMO's signing a risk contract agree to provide all defined services at the HMO's risk. In other words, the HMO is responsible for any cost overruns. The beneficiary who enrolls in a risk-contract HMO must receive all medical services except for emergency or urgently needed services from that HMO. This feature is referred to as the "lock-in" provision. Beneficiaries must pay for services received outside of the plan or those services that have not been authorized by the HMO. Neither the HMO's nor Medicare are responsible for payment of out-of-plan services.

The formula used to determine the payment per HMO beneficiary is based on the average adjusted per capita cost (AAPCC), the fee Medicare estimates it would have paid traditional providers (hospitals and fee-for-service physicians) in the same community. HMO's receive 95 percent of the AAPCC, thereby saving Medicare 5 percent on each Medicare HMO enrollee. HMO's also are permitted to charge beneficiaries a monthly premium equal to the value of traditional Medicare deductibles and copayments. (In contrast, HMO's which contract out with Medicare under a "cost" contract are paid on a prospective basis, but are reimbursed for cost overruns.)

In December 1987, there were 1,186,546 Medicare beneficiaries enrolled in TEFRA risk or cost contracts with HMO's or CMP's. This figure represents more than 3.5 percent of the total Medicare population. At that same time, 143 risk contracts and 35 cost contracts had been signed, with another 28 risk contract applications pending. (An additional 576,422 beneficiaries were enrolled in prepaid plans under arrangements other than TEFRA contracts.)

(D) SUPPLEMENTAL HEALTH COVERAGE

From its enactment, Medicare was never intended to cover its beneficiaries' total health care expenditures. Several types of services are not covered at all while others are partially covered but require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare consistently has covered approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered by Medicaid, private supplemental health insurance, and other sources.

According to HCFA's National Medical Care Utilization and Expenditure Survey of 1980, 67 percent of the aged Medicare population has private insurance in addition to Medicare. Of the $41.7 billion in total medical expenses incurred by noninstitutionalized aged Medicare beneficiaries in 1980, Medicare paid 57 percent, patients and their families paid 19 percent, Medicaid paid 8 percent, and private insurance plans paid 16 percent. The likelihood of individuals having private insurance in addition to Medicare increased among those with more education, and those with higher family incomes. Among the Medicare beneficiaries who had private insurance coverage, 82 percent had one private insurance plan, 17 percent had two or more, and 3 percent had three or more. Approximately 54 percent of the aged Medicare beneficiaries with private insurance had Blue Cross/Blue Shield plans, 45 percent had commercial insurance, and 6 percent were enrolled in HMO's or other prepaid health plans.

Private insurance purchased by the elderly generally concentrates its coverage on the uncovered costs, of services such as copayments and deductibles that otherwise are covered by Medicare. For instance, in 1977, 97.6 percent of all privately insured elderly persons with Medicare coverage had supplemental coverage for hospital inpatient services. However, only 40.6 percent had coverage for out-of-hospital prescription drugs.

Section 1882 of the Social Security Act, added by Public Law 96-265, established standards for medigap policies requiring that they provide at least a minimum level of benefits. This was accomplished through the use of loss ratios—minimum expected levels of benefit payouts. Medigap policies sold to individuals must have an anticipated return to policyholders as benefits of at least 60 percent of the premiums collected. This minimum loss ratio was set at 75 percent for policies sold to groups. In addition, section 1882 established Federal criminal penalties for engaging in abusive sales and marketing practices for medigap policies.

The statute incorporated the model regulatory program of the National Association of Insurance Commissioners, setting forth two procedures for determining whether insurance policies meet the Federal standards. First, the statute established that if a State had adopted laws or regulations that are at least as stringent as the Association's model and the Federal loss ratio requirement, policies regulated by the State are deemed to meet the Federal requirements. Second, the statute established a voluntary certification program under which insurance companies could market policies as medigap insurance in States that do not have laws or regulations equivalent to the Association's model. Under such a system, insurers can submit policies and supporting documentation to the Secretary of Health and Human Services. If the Secretary determines that a submitted policy meets Federal requirements, it is certified and can be marketed as a medigap plan.

According to a 1986 GAO study of the medigap market,[12] all but four States had adopted medigap insurance regulatory programs at least as stringent as National Association of Insurance Commissioners. This has resulted in more uniform regulation of medigap insurance and increased protection for the elderly against substandard or overpriced policies. Most large commercial insurers, with premiums of $50 million or more, met the loss ratio requirements of section 1882. However, more than 60 percent of the commercial insurance policies with premiums under $50 million had not met those requirements. The aggregate figures for all individual policies studied by the GAO showed that about 60 cents of every premium dollar was returned as benefits or added to reserves.

Of 142 policies studied by the GAO, the loss ratios of most policies were below the section 1882 targets. However, the loss ratios of both Blue Cross/Blue Shield plans and Prudential Life Insurance usually were above the targets. This is important because these policies are the most frequently purchased. In 1984, the Blue

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[12] U.S. Government, General Accounting Office, Report to the Subcommittee on Health, House Committee on Ways and Means, Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies. October 1986.

Cross/Blue Shield plans had an aggregate loss ratio of 81.1 percent while the Prudential plans had a loss ratio of 77.9 percent.

While the loss ratio is a useful guideline to determine if the benefit level is adequate, it is not a requirement. Therefore, according to DHHS's interpretation of the law, States are not required to monitor loss ratio experience. Furthermore, penalties for medigap sales abuse have been seen as the prerogative of the States because they primarily are responsible for regulating the insurance industry. All States GAO visited had a formal complaint system, within either the State insurance department or the State department of elderly affairs. All States GAO visited also monitored the advertising practices of insurance companies. GAO concluded that section 1882, when combined with State efforts, not only was protecting the elderly against substandard medigap policies, but also was providing them with information on how to select medigap policies. This conclusion has been criticized by some consumer organizations, including Consumers Union, who question the compliance of medigap insurers with the spirit and intent of the law.

2. ISSUES AND LEGISLATIVE ACTIONS

(A) CATASTROPHIC HEALTH CARE LEGISLATION

The catastrophic health care costs issue so dominated congressional health policy debate and actions during 1987 that it appeared, at times, that the Congress either was unwilling or unable to confront any other health issue. While other health policy concerns periodically were raised and, in some cases, eventually addressed, advocates of these concerns had to accept the fact that 1987—as far as the Congress was concerned—would be the year dedicated to the development of a catastrophic health care bill.

(1) Defining Catastrophic Illness

Prior to addressing the shortcomings of public and private health insurance protection against the costs associated with a catastrophic illness, a definition of the term had to be developed. While most agreed that a catastrophic illness could be defined as a major—usually unexpected—financially unmanageable illness, there were varying opinions on what amount of health care expenditure qualifies as a true catastrophic expense. In response, many rather arbitrarily chose a specific figure, for example $2,000, to define a catastrophic health care expenditure. Other health policy analysts advocated the use of a certain percentage of total annual income, for example 10 percent, to obtain a more accurate picture of the number of people who experience catastrophic health care expenses.

Because the percentage approach takes into account the financial means of the ill person, few disputed its superiority. Such an approach helped illustrate that a $2,000 health care bill for someone making $12,000 a year represents a catastrophic expense, while the same bill for someone earning $100,000 a year may not. At the same time, however, few questioned the practical administrative and political difficulties of being able to use the percentage method to set qualifications for a major expansion of the Medicare Program. Therefore, while Members of Congress and the administration used every measuring method available to guide them in constructing the catastrophic health legislation, they chose to rely upon a minimum base health care expense figure to set eligibility provisions.

(2) Shortcomings of Current Medicare Coverage

In recent years, the fact that there are major gaps in catastrophic health care insurance for millions of Americans of all ages has not been questioned significantly. Even with Medicare, the elderly remain susceptible to catastrophic health care costs. Using varying thresholds and percentages of income figures, DHHS has estimated that as many as 2.1 million elderly (8.1 percent) would experience catastrophic health care expenses in 1987.[13]

Although Medicare provides excellent hospital benefits, coverage for long-term hospital stays (more than 60 days) is limited and leaves elderly patients vulnerable to catastrophic out-of-pocket expenses. In 1987, after day 60 in a hospital, the Medicare beneficiary was liable for a $130 daily copayment. After day 90, the same beneficiary had to pay $260 a day. At these rates, such expenses quickly can become "catastrophic."

Other non-Medicare-covered expenses that either can be or contribute to becoming catastrophic costs are the expenses associated with long-term nursing home care, outpatient prescription drugs, and physician charges above the Medicare assigned rate. In addition, expenses incurred from optical, dental, and hearing services and products continue to represent a significant out-of-pocket cost burden that are not covered by Medicare.

Without question, the greatest catastrophic health care expense is that associated with the provision of long-term nursing home care. At an average annual cost of $22,000 a year, nursing home expenses dwarf all other non-Medicare-covered services. It has been estimated that one-third of elderly households would be financially ruined if one family member were to spend 13 weeks in a nursing home. The beneficiary will qualify for Medicaid assistance only after becoming, for all practical purposes, destitute. (Further discussion of this problem can be found in chapter 9.)

Although long-term nursing home care is extremely expensive, and despite the fact that one in four elderly can be expected to require nursing home care at some point in their lives, the likelihood of needing such care pales in comparision to the likelihood of requiring prescription drugs. Every year, 75 percent of all older Americans consume prescription drugs. For many elderly, the cost of these non-Medicare-covered outpatient prescription drugs can run into the hundreds, and even thousands, of dollars per year. An American Association of Retired Persons survey found that, of those elderly who regularly take prescription drugs and do not have private supplemental health insurance which covers these costs, 40 percent spent more than $360 on prescribed drugs in 1986.

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[13] U.S. Library of Congress, Congressional Research Service. Catastrophic Health Insurance: Medicare. Issue Brief No. IB 87106, by Jennifer O'Sullivan, October 30, 1987 (continually updated). Washington, 1987. p. 2 and Department of Health and Human Services, Catastrophic Illness Expenses. Report to the President, Nov. 1986.

For low-income elderly on fixed incomes, these high costs can and do represent catastrophic expenses.

Further, because prescription drug prices have increased at a rate two and half times faster than the rise in consumer prices from 1980 through 1986, many insurers have dropped coverage of prescription drug costs from their medigap policies. Most, if not all of those policies that continue to offer the benefit have significantly increased their premiums, making it extremely difficult for many elderly to afford the coverage.

Right behind prescription drug expenses, non-Medicare-covered physician charges represent the next highest out-of-pocket liability. Although Medicare reimburses 80 percent of what the program considers a reasonable charge, physicians who do not accept assignment can and do charge more than the program-determined reasonable charge. As a result, Medicare beneficiaries not only are liable for the additional 20 percent of the charge Medicare deems reasonable, but also are liable for any amount over and above the Medicare assigned rate. From 1980 to 1986, beneficiary liability for noncovered physicians costs increased by almost 100 percent, from $1.45 billion to $2.8 billion.[14]

Private insurers offering supplemental insurance (medigap) coverage to the elderly have been hesitant to offer policies that do more than build upon what Medicare covers. Consequently, many elderly have found it particularly difficult and/or unaffordable to find policies that cover long-term nursing home and home health care, prescription drugs, and physician costs that are more than the Medicare approved rate. It appears, therefore, that until a significant private and/or public insurance initiative is developed to address these and other shortcomings, the elderly—particularly the low- to middle-income elderly—will continue to live in fear of incurring catastrophic health care costs.

Millions of nonelderly Americans are at least as vulnerable to catastrophic health care costs. There are 37 million persons under 65 who have no health insurance and are completely vulnerable to being financially devastated by a catastrophic health incident. Moreover, millions more have inadequate protection against catastrophic health care costs. Using varying thresholds and percentages of income figures, DHHS estimated that as many as 6.2 million (3.2 percent) of the under-65 population were victimized by catastrophic health care expenses in 1987.[15] Despite receiving a great deal of attention in the 1986 DHHS catastrophic health care report and in a number of congressional hearings in 1987, the lack of health insurance protection of the under-65 population was not significantly addressed in either the Senate or House catastrophic bills.

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[14] Varner, Theresa. Catastrophic Health Care Costs for Older Americans: The Issue and Its Implications for Policy Development. American Association of Retired Persons Public Policy Institute, June 1987. p. 16.

[15] U.S. Library of Congress. Congressional Research Service. Catastrophic Health Insurance: Medicare. Issue Brief 87106. p. 2.

(3) Administration's Actions to Address Shortcomings

When President Reagan initially mentioned his desire to better protect Americans against catastrophic health care costs in his 1986 State of the Union Address, he started the ball rolling toward what now appears to be certain passage (by the conclusion of the 100th Congress) of legislation which begins to accomplish this goal. Although it is not a new issue (many Members of Congress had introduced legislation in previous sessions), the administration's willingness to move forward on the catastrophic health care front breathed new life into the issue.

(a) Bowen report on catastrophic health care

In the 1986 State of the Union Address, the President announced that he had directed the Secretary of DHHS to study the catastrophic health care issue and develop recommendations to address health insurance shortcomings. Although an encouraging development, many critics were skeptical of what, if anything, would come of this report. However, when the report was released in 1986, most of the critics were pleasantly surprised and praised Secretary Otis Bowen for the scope of the study and the thoughtfulness of the report's recommendations.

The report provided a comprehensive analysis of the shortcomings of current public and private insurance coverage of catastrophic health care legislation. It focused on three vulnerable groups: The elderly who face large out-of-pocket costs associated with lengthy, non-Medicare covered hospital stays for acute illnesses, older Americans who require long-term care, and the vulnerable uninsured and underinsured under-65 population.

To most health policy analysts, the report's recommendations for addressing the lack of catastrophic protection for the under-65 population and for those elderly needing long-term care were not unexpected. These recommendations placed heavy emphasis on encouraging (through tax incentives) the development of private sector, State, and local initiatives.

Specifically, Secretary Bowen's long-term care proposal consisted of recommendations to: (1) Provide tax incentives and other inducements for the private sector to develop and market long-term care insurance more actively, (2) encourage the use of individual medical accounts (IMA's) in a way that individual retirement accounts (IRA's) had been used prior to the Tax Reform Act of 1986, and (3) provide much-needed information to the public about the costs, potential for requiring, and the limitations of Medicare coverage of long-term care.

The administration made similar recommendations with regard to catastrophic protection for the under-65 population. To encourage employers to provide catastrophic protection for their employees, the Secretary recommended comprehensive tax deductions to those who provided such coverage to their employees. With regard to State involvement, the proposal which received the most attention was a recommendation to encourage States to develop, with guidance from the Federal Government, insurance risk pools for medically uninsurable citizens (those who cannot obtain insurance due to previous major medical conditions and/or lack of income).

Risk pools would require that all health insurers in the State contribute to developing and offering a feasible health insurance option for these high-risk populations.

Although the analysis of the numerous problems surrounding the lack of long-term care insurance for older Americans and catastrophic health care protection for the under-65 population was comprehensive, the proposed recommendations to deal with these problems were viewed by many health policy analysts to be inadequate and/or politically unrealistic. The long-term care proposals were criticized on the grounds that their tax incentives might well benefit the relatively wealthy, but would leave large gaps in protection for middle- to lower-income brackets. In particular, critics argued that IMA's, like IRA's, would be taken advantage of primarily by upper middle- to upper-income groups. Further, bipartisan criticism pointed to the fact that the IMA recommendation was inconsistent with a provision of the 1986 Tax Reform Act which significantly limited the use of IRA's. The proposals to deal with the underinsured and uninsured under-65 population were given similarly negative reviews, and—like the long-term care proposals—were not incorporated into any catastrophic legislation during 1987.

Far and away the most widely heralded—and surprising—recommendation was the Secretary's proposal to restructure the Medicare Program to include a beneficiary-financed, actuarily-sound, acute care catastrophic benefit. This was an unusual departure for an administration official because it represented one of the first Reagan administration health proposals to depart from its customary reliance on the private sector and/or the States to address a critical need.

While Secretary Bowen's acute catastrophic care recommendation received praise from many in the Congress, it also was the recipient of much criticism from conservatives in and outside of the White House. In a New York Times article, Peter J. Ferrara, a former Reagan domestic policy adviser, called the proposal "reverse privatization, blatantly and directly contrary to the President's policies." Despite the criticism and after much debate within the White House, Secretary Bowen's acute care catastrophic proposal eventually was endorsed by the President and served as the basis not only for the legislation the administration submitted to the Congress, but also for all other catastrophic bills as well.

(b) Administration's legislative proposal

In February, the minority leaders of the Senate and House introduced S. 592 and H.R. 1245 on behalf of the President. Both bills incorporated Secretary Bowen's proposal to address the acute catastrophic health care gaps of the elderly. However, the legislation did not address the shortcomings of catastrophic protection for the most costly catastrophic expense of the elderly (long-term care) or the lack of coverage of the 37 million uninsured population under 65.

Specifically, these companion bills incorporated Secretary Bowen's acute care catastrophic recommendation to place an annual limit of $2,000 on each Medicare beneficiary's out-of-pocket costs for all Part A and Part B deductibles and coinsurance. In his report, Secretary Bowen had estimated that the implementation of such a benefit would cost $4.92 a month for each Medicare beneficiary. This amount, $59 per year, would be added to the Part B premium and would provide protection, according to the Secretary, to the more than 1.3 million beneficiaries who were expected to incur program-related expenses in excess of $2,000 in 1987. Under this legislation, the benefit would be voluntary in the sense that the beneficiary could elect to buy into the catastrophic benefit. However, if he or she did, the beneficiary also would be required to elect the Part B protection. Similarly, if the beneficiary opted for Part B (as more than 98 percent of the elderly currently do), he or she would have to pay for the catastrophic benefit as well.

(4) Congressional Response

The Congress, weary and frustrated of its role of spending the majority of its time trying to control health care costs rather than address health care needs, heartily welcomed Secretary Bowen's report. After a long respite, the administration finally had opened its doors to the possibility of a major health initiative. Members quickly recognized that, regardless of whether the President followed the report with an endorsement for legislation, they could use the report and its recommendations as a vehicle for legislative action.

Even prior to the introduction of the administration's bill, Members of Congress quickly scheduled hearings on the catastrophic health care issue and introduced various versions of the legislation. In fact, the first catastrophic health bill submitted in the 100th Congress was introduced by Senators Kennedy and Melcher almost 2 months before the administration submission. This bill, S. 210, was introduced to incorporate the most highly praised recommendation of the Bowen report—the recommendation to restructure Medicare to include an acute care catastrophic benefit.

(a) Hearings

Soon after S. 210's introduction, Senator Melcher conducted two Special Committee on Aging hearings on the catastrophic health care issue. At the first hearing, held on January 26, 1987, members received testimony from catastrophic health care victims of all ages, health insurers, and consumer advocates. Chairman Melcher held the hearing to evaluate the extent of private and public catastrophic insurance and to illustrate the need for a Federal response. At the second hearing, a joint Senate/House Aging Committee hearing held 2 days later, one witness was invited to testify—Secretary Otis Bowen. This hearing gave the members of the two Aging Committees an opportunity to ask Secretary Bowen about his report and how President Reagan had received it.

The Aging Committee hearings, and hearings held by the Senate Labor and Human Resources Committee, the Finance Committee, the House Ways and Means Committee, and the Energy and Commerce Committee praised Secretary Bowen for his report, but also raised concerns about its failure to address the lack of protection against costs associated with long-term care, prescription drugs, and the under-65 uninsured issue.

With regard to the acute care catastrophic benefit, many members (although impressed with Secretary Bowen's proposal) questioned the validity of the Secretary's estimates regarding the cost of the benefit and how many people it would benefit. These members cited estimates that the actual 1988 premium would not be $4.92 per month, but closer to $6.10. Concerns also were raised about the difficulty for low-income beneficiaries to pay an additional $72 per year in premiums for a catastrophic benefit. In addition, members pointed to estimates indicating that, while there were approximately 1.3 million beneficiaries who incurred Medicare deductible and coinsurance costs of over $2,000, 80 percent of this population already had medigap and/or Medicaid coverage that provided significant catastrophic acute care protection. The American Association of Retired Persons, the National Council of Senior Citizens, and other aging advocate organizations stressed that health care costs of $1,000 or even less represented catastrophic costs to many low-income elderly.

(b) Legislative development

The House of Representatives moved more rapidly than the Senate in developing, introducing, marking up, and passing the catastrophic legislation. However, the primary debate in both Houses of Congress consistently centered around how the benefit would be financed and whether it would cover prescription drugs.

Beyond the Kennedy/Melcher catastrophic bill, a number of diverse catastrophic health care bills were introduced to address some of the concerns outlined during the hearings. Senator Dole introduced S. 754 that, other than including a provision that would count the costs of immunosuppressive drugs (extremely expensive medications used after an organ transplant) toward his $1,800 catastrophic cap, differed little from the administration bill. Representative Pepper introduced the much more comprehensive H.R. 65 that proposed adding a new Medicare Part C to cover prescription drugs, institutional and home- and community-based long-term care, and dental and vision care. Not surprisingly, though, the bills that received the most attention emerged from the congressional committees (the House Ways and Means Committee, the House Energy and Commerce Committee, and the Senate Finance Committee) with legislative jurisdiction over the Medicare Program.

In the House, Representatives Stark and Gradison, Chairman and Ranking Member of the Ways and Means Subcommittee on Health, quickly moved to introduce two bills (H.R. 1280 and H.R. 1281), that would initially serve as the legislative vehicle for House actions on the catastrophic health issue. These bills built on the Bowen proposal by lowering the annual limit on out-of-pocket costs for Medicare covered services, expanding Medicare's skilled nursing home and home health care benefit, increasing mental health coverage, and requiring that States pay the new cost-sharing charges up to the catastrophic limit for the very low-income elderly. Significantly, this legislation did not include a prescription drug benefit.

The Stark/Gradison legislation originally was to be paid for by taxing part of the actuarial value of Medicare's benefits. However, after hearing significant concerns from representatives of labor, aging advocacy groups, and insurers (who feared that such an approach would set the precedent of taxing non-cash benefits), the bill's sponsors agreed to alter their financing approach in favor of a supplemental premium based on the actual income of elderly taxpayers.

Led by Representatives Dingell and Waxman, a coalition of Congressmen were successful in including a prescription drug benefit in the catastrophic bill that emerged from the House Energy and Commerce Committee. To assure that the legislation would make it to the floor and could be supported by key Members of the House and aging advocates, the chairman of the Ways and Means Committee, Representative Rostenkowski, and Representative Stark agreed to include a prescription drug benefit (beginning in 1989 with a separate catastrophic $500 deductible) in the final catastrophic bill that was reported to the House floor. The House of Representatives passed the bill on July 22.

The Senate committee with jurisdiction over the Medicare program, the Finance Committee, held hearings on a bill (S. 1127) that had been introduced by the chairman of the committee, Senator Bentsen. Although the bill's benefits were slightly less liberal than the House version, its financing approach was viewed by many as striking a strong compromise between Secretary Bowen's across-the-board flat premium proposal and the predominant reliance on a supplemental premium approach included in the House version. The Senate bill would reduce the amount of the flat premium that the administration advocated and would set up a more progressive supplemental premium than what was included in the House proposal. In addition, similar to the early versions of the House bill, the Senate bill originally did not include a significant prescription drug benefit.

During markup of S. 1127, Senator Heinz raised the issue of adding a prescription drug benefit. Of major concern to a number of committee members was the great disparity in projected cost estimates from the Congressional Budget Office (CBO) and the Health Care Financing Administration (HCFA) for such a benefit. The cost of the benefit also was a particular concern to many Members because the elderly would pay, under the financing approach chosen by the Finance Committee, the entire cost through a premium. Chairman Bentsen agreed to hold a hearing on the prescription drug issue and suggested the possibility that more expansive coverage might be considered as an amendment to S. 1127 during Senate floor consideration.

Chairman Melcher, an advocate of a strong Medicare prescription drug benefit, authorized two Aging Committee hearings on this issue. Both hearings, one of which was chaired by Senator Pryor in Arkansas, highlighted the significant out-of-pocket burden prescription drug costs create for the elderly. Testimony highlighted the fact that seniors, though they constitute only 12 percent of the population, consume approximately 30 percent of all prescription drugs. Poignant personal accounts by elderly witnesses described how difficult it was for many other Americans to afford their prescription drugs expenses and, at the same time, pay for other basic essentials such as groceries, utilities, and rent.

Two General Accounting Office reports on catastrophic health released by Chairman Melcher cited Public Health Service findings which concluded that 15.5 percent of the elderly who require prescriptions report that they are unable to pay for their drugs.[16] Further, information provided by the Congressional Budget Office indicated that 17 percent of Part B enrollees spend more than $500 annually for their prescription drugs, and therefore, would benefit from the out-patient prescription drug coverage that would be provided by the House bill. With this information, GAO concluded in one of its reports that the $500 deductible would keep this provision from helping some of the elderly who need it the most—the poor, near poor, and those who do not have private supplemental insurance.

Despite the finding that many elderly desperately need protection against prescription drug costs, concern remained high about the cost of a drug benefit. For months, a coalition of Senators placed holds on the catastrophic bill, threatening to filibuster any attempt to bring it to the Senate floor for a vote. Because there were a number of other priority legislative items pending, the Senate leadership did not want to spend unnecessary time on a bill that would be filibustered, and opted to delay action until an acceptable agreement could be forged. Finally, a group of Finance Committee members, including Senators Heinz and Mitchell successfully negotiated a compromise with the administration to clear the way for floor action.

On October 27, 1987, the Senate catastrophic bill was sent to the floor for consideration by the full Senate. Senators Heinz, Mitchell, and others offered the compromise catastrophic drug amendment to the bill. Although much more modest (a benefit with a $600 deductible beginning in 1990, but not completely phased in until 1993) than either the House bill's drug provisions or an approach that Senator Melcher previously had advocated, a number of Senators continued to raise concerns about the potential costs of the amendment. A long debate followed and it became obvious that the Senate would not support a more liberal amendment.

As a result, Senator Melcher did not offer his more comprehensive prescription drug amendment, but instead offered a perfecting amendment to the Heinz-Mitchell amendment which would give the DHHS Secretary authority to reduce the prescription drug deductible if sufficient revenue were generated. Prior to this amendment, the Secretary could only increase the amount of the deductible. As was the case with the Heinz-Mitchell amendment, the Melcher amendment eventually was passed and was incorporated into the final bill.

Despite great initial momentum to sign catastrophic health care protection legislation into law by the end of 1987 and despite the fact that separate catastrophic health bills were passed in both Chambers of the Congress, no final bill was passed. In fact, the Senate/House conference committee appointed to work out a compromise bill did not even meet prior to the Christmas recess. The lack of action was largely due to the fact that many of the conferees were participating in the budget summit following the October stock market crash. Further, when it became clear that there likely would not be sufficient time to fully implement the legislation before late 1988 or, more likely, 1989, there was not as much pressure for the conferees to meet before 1988. A compromise bill is expected to be reported out of the conference in 1988.

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[16] U.S. General Accounting Office. Medicare: Prescription Drug Issues. Report to the Chairman, Special Committee on Aging, U.S. Senate. PEMD-87-20, July 1987. Washington 1987.

(5) Major Provisions of Catastrophic Health Care Bills

Although the two versions of the catastrophic health care legislation that passed the House and the Senate are similar in many ways, there are significant differences in some provisions. The major provisions of these bills are described below.

(a) Eligibility

One of the most significant differences between the two catastrophic health bills is that the Senate version, unlike the House version, provides that the new catastrophic benefit would be optional and that Medicare would retain the current benefit structure for Part A-only enrollees. The Senate approach would not provide any catastrophic protection, unless the beneficiary opted for the benefit. By contrast, the House version would provide the benefit expansions (that would improve the Part A benefit) to all beneficiaries eligible for Part A. However, regardless of whether the beneficiary opted for the Part B benefit, he or she would be required to pay the income-tested catastrophic supplemental premium which pays for the great majority of the new catastrophic provisions.

(b) Benefits

Catastrophic limit.—The Senate version would count required copayments under part A and part B towards the catastrophic copayment cap, eliminate the hospital copayment, and revise skilled nursing facility (SNF) copayment requirements. The cap would be set at $1,850 in 1988 (if implemented) and $2,030 for 1989. In subsequent years, the limit would be indexed to increases in charges per enrollee (for catastrophic, but not drug benefits). The House version also would eliminate hospital copayments and revise SNF copayments; but it would not count Part A cost sharing toward the catastrophic cap. The Part B cap would be set at $1,043 in 1989. In subsequent years, the limit would be indexed to the annual Social Security cost-of-living adjustment.

Inpatient hospital services.—The new provisions regarding inpatient hospital services are the same. Both House and Senate versions of H.R. 2470 would provide coverage of an unlimited number of days in a hospital and eliminate the current "spell of illness" concept (which covers up to 90 days of inpatient services per spell of illness, plus up to 60 lifetime reserve days). In addition, both versions eliminate the provision under which beneficiaries must pay their hospital deductible every time they are admitted for a new spell of illness and substitute a provision whereby the deductible is applied only once per calendar year. Finally, both versions eliminate the daily coinsurance charges (currently set at 25 percent of the inpatient deductible for days 61–90 in a spell of illness and 50 percent of the inpatient deductible for any used lifetime reserve days).

Catastrophic prescription drug benefit.—The differences in the House-passed and Senate-passed prescription drug benefit provisions are expected to be some of the most difficult to reconcile. In light of the complexity of the two approaches, what follows is a relatively comprehensive outline of the provisions.

House of Representatives:

> Beginning January 1, 1989, Medicare would cover 80 percent of the costs of outpatient prescription drugs and insulin after a $500 per beneficiary annual deductible is met; the deductible would be indexed in 1990 and 1991 to the medical care component of the consumer price index (CPI). The Secretary of DHHS would establish an appropriate index for prescription drugs to be used on the deductible for 1992 and beyond. The drug deductible could not be applied to the $1,043 out-of-pocket Part B limit; the current separate $75 Part B deductible would be retained.
>
> Seventy-five percent of the cost of the coverage would be paid for by an additional premium of $2.30 per month beginning in 1989. In 1990, the premium would not exceed $3.60 per month. Beyond 1990, the premium would increase by the lesser of 20 percent or the amount needed to meet program costs (as determined by the Secretary of DHHS). Premiums would be reduced if the program ran a surplus. Twenty-five percent of the costs would be financed by the supplemental premium.
>
> A participating pharmacy program would be established. These pharmacies would be bound to dispense in-stock pharmaceuticals to Medicare beneficiaries at a rate not to exceed that charged the public, and to keep records of beneficiaries' purchases to help them determine when their annual deductible has been met. The pharmacy also would notify Medicare carriers when the deductible is met.
>
> Generic drug payment limits (as set by DHHS in accordance with requirements established in bill) would be imposed for drugs with generic equivalents, unless the physician specifies that the brand-name item is medically necessary. DHHS would establish drug payment limits which take into consideration drug costs, administrative expenses, and overhead. The Secretary would develop guidelines to prevent abusive practices in the prescribing or dispensing of drugs. Under no circumstances could prescriptions for more than a 60-day supply of a drug be reimbursed at one time.
>
> The Secretary of DHHS would report to the Congress in May of each year (beginning in 1990) regarding program costs and whether the scheduled premium is sufficient to meet those costs. The Secretary also would make recommendations on program changes which might reduce expenditures. This version also authorizes a number of studies regarding outpatient drug coverage, and would create a Prescription Drug Payment Review Commission to make recommendations to the Congress annually on methods for Medicare payment of outpatient prescription drugs.

Senate: The final Senate benefit is somewhat similar to the House-approved benefit, although it would be phased in more gradually:

> Beginning in January 1990, Medicare would cover 80 percent of the cost of prescription drugs after beneficiaries met a separate deductible of $600. The deductible would be indexed to reflect the average increase in beneficiary prescription drug costs. In 1990 the benefit would cover immunosuppressive and anticancer drugs and intravenous antibiotics. In 1991 and 1992 coverage would be expanded to include diuretics and antihypertensives, and in 1993 all prescription drugs would be covered.
>
> The new benefit would be financed through a combination of increases in the basic and supplemental premiums. The basic premium could not exceed 90 cents in 1990, $2 monthly in 1991, $3.50 in 1992, and $4.05 in 1993. The supplemental premium would be designed to cover 50 percent of program costs when the program is fully implemented. If program costs exceed the premiums allowed under the statute, the Secretary of DHHS would be authorized to reduce program costs. If program costs are less than expected in the initial years, the Secretary could reduce the deductible in those years.
>
> A participating pharmacy program similar to the House legislation would be established; additional studies regarding prescription drug coverage and costs would be authorized.
>
> The Secretary of DHHS would be required to establish drug payment limits. Reimbursements at no more than 150 percent of the lowest cost generic drug would be set unless the prescribing physician specifies the brand name drug as medically necessary. The legislation includes language similar to the House version on inappropriate dispensing and prescribing practices.

The financing method, the extent of coverage, and the issue of phasing in the prescription drug benefit are expected to be the most hotly debated aspects of the drug provision during Senate-House conference committee deliberations on the catastrophic package.

Skilled nursing facility services.—Both Senate and House versions would increase the skilled nursing facility (SNF) benefit from its current level of 100 days per spell of illness to 150 days per year and also would eliminate the prior hospital requirement. In addition, both versions would significantly alter the way the daily SNF coinsurance is calculated. Although slightly different formulations are proposed, both effectively would reduce the coinsurance amount and would apply it to the initial days of care (the first 7 days in the House version, the first 10 days in the Senate version), rather than days 21–100.

Hospice services.—Both Senate and House versions remove the 210-day Medicare cap for reimbursement for hospice servcies, as long as the patient is recertified as terminally ill.

Home health services.—Under current Medicare law, home health services are covered if they are required because the patient is homebound and requires skilled nursing care on an intermittent basis (defined as daily skilled nursing visits for up to 2 or 3 weeks).

Both versions of the catastrophic health care bill include provisions to improve this benefit.

The Senate version incorporated a key provision from S. 1076, the Medicare Home Care Services Improvement Act, introduced by Senators Bradley, Mitchell, Heinz, Pryor, Glenn, Melcher, and others. The provision extends the number of days for which beneficiaries enrolled in Part B can receive daily home health benefits. For these beneficiaries, 45 days of daily care would be allowed if the beneficiary were discharged from either a hospital or SNF within 30 days prior to beginning home health care. This benefit expansion would provide increased services for roughly 250,000 Medicare beneficiaries each year. (In addition, the Senate version includes a clarification on Medicare's "homebound" definition. However, this provision no longer is germane because it was included in the Omnibus Budget Reconciliation Act of 1987 and is discussed later in this chapter.)

The House provision expands coverage of daily care to 35 days. However, unlike the Senate provision there is no prior hospitalization requirement. In addition, the House version provides that home health payments be made under Part B. (Under current law, practically all home health benefits are provided under Part A.)

Outpatient mental health services.—The Senate version would retain current law. The House version raises Medicare's maximum payment from its pre-1988 level of $250 to $1,000. However, this provision should not be the subject to dispute because the Omnibus Reconciliation Act of 1987 included a provision that increases the maximum payment from $250 to $450 in 1988 and the $1,000 in 1989.

Respite services.—The Senate version contains no provision related to Medicare coverage of respite care. However, the House version would cover up to 80 hours a year of in-home respite care for chronically dependent persons.

Home intravenous drug therapy.—The Senate version would cover intravenous drug therapies provided in the home under a plan established by the physician. Coverage includes nursing, pharmacy, and related services necessary to safely and effectively conduct an intravenously administered anti-infective or cancer therapeutic drug regimen. The House version contains no such provision and, therefore, would not alter current law, which only covers drugs and biologicals that cannot be self-administered and that are furnished as part of a physician's service.

(c) Financing

Along with the prescription drug provision, the differences in the financing approaches of the Senate and House versions will be the most difficult provisions to reconcile. Both the Senate and House plans rely on a mix of flat- and income-related premiums, but the Senate plan would rely more heavily on flat premiums than the House plan. In the Senate plan, from 1988 to 1992, about 45 percent of the projected additional premium receipts would come from flat premiums which only 5 percent of receipts would be from flat premiums under the House plan. However, although the Senate's income-related supplemental premium's ceiling of $850 (in 1989) is higher than the House's supplemental ceiling of $737 (in 1989), the

Senate income-related premium is a more progressive addition to income tax rates.[17] The following summarizes the two financing approaches:

Senate version.—The Senate version would finance its new catastrophic benefits through a two-part additional premium for Part B enrollees, a flat and a supplemental premium. All Part B enrollees would be required to pay, in addition to their current Part B premium, a new catastrophic flat premium of $4 per month in 1988. (Increases in this flat premium would be indexed to costs of the catastrophic benefit—excluding drugs—plus, for years prior to 1993, the percentage necessary for a contingency reserve fund to 20 percent.) Beginning in 1990, an additional flat premium would be added to cover a portion of the costs of the new drug benefit. This flat premium would be phased in to represent 50 percent of the cost of the drug benefit as long as it does not exceed certain premium limits: 90 cents in 1990, $2 per month in 1991, $3.50 per month in 1992, $4.05 per month in 1993.

In addition to the flat premium, Part B enrollees with an income tax liability of $150 or more would pay a supplemental income-related premium designed to cover the remaining costs of the new benefits. The income-related premium rate would be $13.08 for each $150 of tax liability in 1988, up to the maximum liability of $800 per enrolee per year. The premium rate and the maximum liability would reflect growth in benefits per enrollee, so that it would increase to $14.76 and $850 respectively in 1989. Although the income-related premium would be a deductible expense, unlike the House version, and despite the ceiling on liability, receipts would keep pace with costs because the Secretary would be directed to adjust rates as necessary to accomplish that goal.

House version.—Similar to the Senate, the House version's benefits would be financed in a multifaceted manner: (1) A new flat premium based on the sum of an ad hoc premium amount in 1991 and 1992 and the projected costs of the new in-home personal care benefit (30 cents per month in 1989) and 75 percent of the costs of the new drug benefit ($2.40 per month in 1989), and (2) a supplemental (nondeductible) income-related premium requiring enrollees filing individual returns for 1988 to pay an amount equal to $10 for each $143 of adjusted gross income (AGI) in excess of $6,000 ($6,258 in 1989) up to a maximum liability of $580 in 1988 ($700 in 1989). Like the Senate version, these premiums and supplemental premiums would be indexed to various program costs and inflation rate formulas. Unlike the Senate version, the income-related premium would not be a deductible expense. Chart 8 illustrates, by income levels, the premiums—combining both flat and income-related—that would be paid by individuals under the two proposals (excluding the drug premiums) in 1989.

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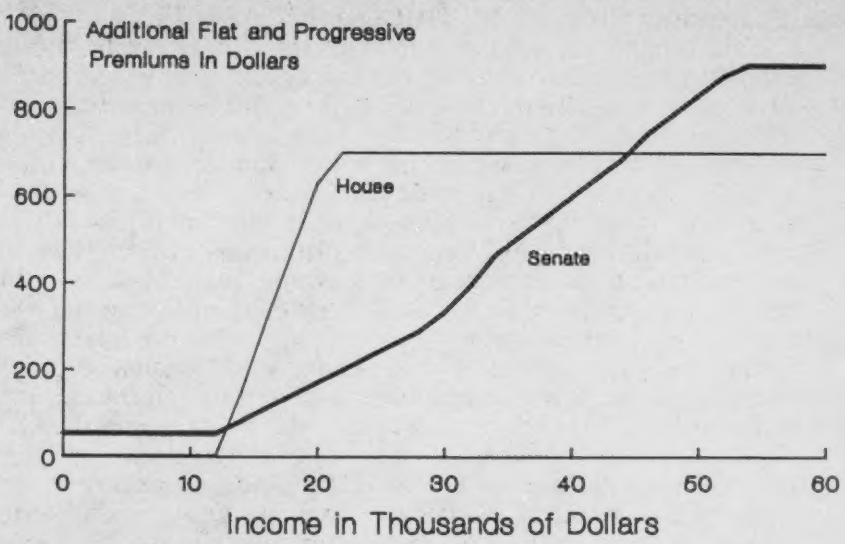
[17] The summaries of the specific financing provisions, as well as the general provisions of the catastrophic health care bills, rely heavily on U.S. Congress, Congressional Budget Office, A Comparison of House and Senate Catastrophic Bills. Washington, D.C., December 16, 1987.

CHART 8

Additional Premiums Under House and Senate Plans by Income, 1989*



Source: Congressional Budget Office
* Excluding drug benefit

(d) Beneficiary notification

Both Senate and House versions contain language that directs the DHHS Secretary to notify beneficiaries what Medicare does and does not cover. The House would further direct the Secretary to provide information about Medicaid coverage. Unlike the House version, the Senate version includes a provision which would authorize the Secretary to contract out to nonprofit organizations for the purpose of training volunteers to provide Medicare and Medicaid benefits counseling to the elderly.

(e) Medicare supplemental policies

Both Senate and House versions include provisions to use the recommendations of the National Association of Insurance Commissioners (NAIC) to set New Federal Standards for Medicare supplemental (or medigap) policies to reflect the new benefits under Medicare following the enactment of the catastrophic health care bill. The senate version provides that the NAIC recommendations would become the standard if NAIC revises current standards within 90 days of enactment. The House bill requires the DHHS Secretary to take the NAIC recommendations into account for a mandated report that would be due within 150 days of enactment.

(f) Federal retirees

Following House passage of its version of the catastrophic health care legislation, two major concerns were raised regarding the adverse effect this legislation would have on Federal retirees (as well as many other public and private sector retirees): (1) The financing of the plan which includes an assessment of a higher supplemental premium on non-Social Security retirement income, and (2) the duplication of benefits already provided by the Federal Employees Health Benefits Program (FEHBP) health plans.

Financing.—As earlier outlined, the financing of the supplemental premium under the Senate package is based on Federal income tax liability; the House proposal is based on adjusted gross income. Social Security income is only partially subjected to income taxation, while most pension or annuity income is taxable. Because of the wide variation in tax treatment of retirement income, two retirees with identical pretax incomes could be charged supplemental premiums which vary greatly depending on their source of income, regardless of which financing proposal (House or Senate) is implemented. Federal and other public sector retirees who did not participate in Social Security during their working years would be particularly hard-hit by either supplemental premium financing plan.

To address this concern, the Senate version includes a provision, authored by Senators Pryor and Domenici, which would provide an adjustment to the supplemental premium and the Federal tax liability used in computing the supplemental premium for any individual receiving less than $6,000 in Social Security income ($9,000 for a couple). The $6,000 and $9,000 figures approximate the average Social Security benefit for an individual and a couple, respectively. Although this formula would not provide complete equalization between Social Security and other retirement incomes for purposes of calculating the supplemental premium, it would provide some relief for those whose retirement incomes come primarily from sources other than Social Security.

Duplication of benefits.—The Office of Personnel Management (OPM) estimates that approximately 760,000 Federal retirees are also Medicare eligible. Many Federal retirees enroll in Medicare (Parts A and B) in addition to participating in one of the FEHB plans. In such instances Medicare acts as the primary payor and the beneficiary's FEHBP coverage fills in some of the "gaps" in the Medicare Program. However, the Federal Government as an employer must offer identical health care coverage to all employees (active and retired), and the plans are not coordinated with Medicare (as are private sector Medicare supplemental policies). The lack of coordination between FEHBP plans and Medicare results in overlapping benefits and increased health insurance costs. While many retirees are willing to pay the premiums for coverage under FEHBP and Medicare in order to receive more comprehensive coverage, it is highly doubtful that most of these retirees would be willing to pay for further duplicative coverage under the catastrophic plan.

In response to this situation, Senators Stevens, Melcher, and Pryor authored a provision included in the Senate version which would require OPM to reduce health insurance premiums for any Federal retiree participating in both Medicare and

FEHBP and receiving duplicate coverage. The rebate would be equivalent to the estimated cost of medical services and supplies which, barring Medicare catastrophic coverage, would have been paid for by the FEHBP plan. This provision also would direct OPM to report back to the Congress no later than April 1, 1989, with a specific legislative proposal for providing health insurance coverage which supplements Medicare coverage under FEHBP. Finally, this provision would require OPM to study and report to the Congress on the feasibility of applying the medigap standards to be developed by the National Association of Insurance Commissioners to the new Medicare supplemental policies to be offered under FEHBP.

(g) Medicaid provisions

As the catastrophic health care legislation developed, the authorizing committees in both Houses of Congress determined that, due to severe budget constraints, the measure should be financed in a budget neutral manner. Many Members of Congress were concerned that the increased premiums necessary to pay for the expanded coverage would create severe financial difficulties and/or reduce access to needed health care services for low-income senior citizens, and sought to reduce the premium liability for the poorest elderly participants.

With enactment of the catastrophic health bill, States are expected to receive a windfall in the form of Medicaid savings because the new, expanded coverage under Medicare will pick up some costs currently covered under Medicaid. The House version includes a provision which would require States to finance Medicare Part B premiums, copayments, and deductibles for all elderly and disabled enrollees at or below the Federal poverty level. (This provision assumes that the expanded coverage can be financed through the State Medicaid windfall.) The Senate version requires only that any Medicaid savings attributable to the catastrophic health bill be used to finance such cost-sharing charges or for other specified purposes. This issue should receive considerable attention during the joint House-Senate conference committee deliberations on the catastrophic package.

Both versions of the catastrophic health care bills have provisions to address the issues surrounding spousal improverishment (the impoverishment of the spouse of an individual in a nursing home who has been forced to spend-down all assets for the nursing home resident to be able to qualify for Medicaid). This issue is detailed in the long-term care chapter.

(B) MEDICARE SOLVENCY AND COST CONTAINMENT

Controlling health expenditures within the Medicare Program and looking for ways to assure the program's solvency well into the next century continue to be among the highest priority issues for both the Congress and the administration. Total costs for Medicare have steadily increased from $4.6 billion in 1967 (the first full year of the program) to an estimated $80.8 billion in 1987.[18] By 1990 Medicare outlays are expected to reach more than $113.5 billion.[19]

The rise in Medicare costs has been a concern on two levels. First, Medicare has been consuming an increasing share of the Federal spending pie. In 1987, expenditures for Medicare represented 7.6 percent of the total Federal budget.[20] This compares with a little more than 4 percent in fiscal year 1976. With Federal deficits expected to remain close to $150 billion in fiscal year 1988, there are continuing pressures to curb the growth in Medicare outlays. As the second most expensive domestic program, it provides a major target for deficit reduction efforts. While Part A is funded out of the Trust Fund, Part B is largely funded out of general revenues making it a prime target for annual spending cuts. Under current law, 25 percent of the Part B program is financed by premiums paid by beneficiaries. The bulk of Part B expenditures goes to pay for physician services. Thus, as physician payments increase, so too will pressures on the general treasury to finance Part B—a fact that has underscored the need to bring effective cost containment to physician and other Part B expenditures.

A second driving force for Medicare cost containment is the need to assure solvency of the Trust Fund. The introduction of the Prospective Payment System, along with other factors slowing inflation in the medical marketplace, has given new life to the trust fund. In 1984, the Medicare trustees were estimating that the HI Trust Fund would go bankrupt by 1989 under pessimistic economic assumptions and by 1992 under intermediate economic assumptions. In the 1985 report, the trustees revised their projections, estimating that the HI Trust Fund would remain solvent until 1998 under intermediate economic assumptions, and until 1992 under pessimistic ones. In the 1986 HI trustees report, the trustees again revised their projections, moving forward the date of insolvency under intermediate assumptions to 2002, but to 1996 under pessimistic assumptions.[21]

Despite the 1987 projections, there remain a legitimate concern that the present financing schedule for the HI Trust Fund is inadequate to ensure its long-term health. According to the trustees, "in order to bring the HI Trust Fund into close actuarial balance even for the first 25-year projection period under alternative II-B assumptions (intermediate economic assumptions), either outlays will have to be reduced by 13 percent or income increased by 15 percent." [22] Moreover, because of changing demographics, there will be increasingly fewer workers to support each Medicare beneficiary as we move into the next century. Today, four covered workers support each Medicare enrollee. By the middle of the next century, there will be only slightly more than two covered workers supporting each enrollee. According to the trustees, however, all but the most optimistic assumptions indicate that there will be insufficient reserves in the HI program even before this major demographic change begins to occur. Therefore, there is a growing need to find ways to ensure the same level of benefits to future generations of the elderly.

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[18] Table 6, 1987 SMI Trustees' Report.

[19] Table 15, "National health expenditures, 1986-2000."

[20] Congressional Research Service, Report No. 86-46 EPW, 1987 Federal Spending for the Human Resource Programs, by Gene Falk, Feb. 26, 1986. p. 59.

[21] 1987 HI trustees report, p. 55.

[22] U.S. Department of Health and Human Services, Health Care Financing Administration, 1987 Annual Report to the Trustees of the Federal Hospital Insurance Trust Fund. Washington, March 30, 1987, p. 55.

While there is evidence that indicates that the implementation of the prospective payment system has made a contribution to slowing the increases in Medicare inpatient hospital expenditures, the jury is still out on the degree of its success. At a time when health care inflation is still consistently doubling the general inflation rate, there is little debate that much more needs to be done to prevent the future insolvency of the trust fund. In response, Congress may well have to make further systemwide changes to the Medicare Program.

In 1987, the Senate Finance Committee attempted to address the Medicare insolvency issue by recommending in the reconciliation legislation initially reported out of committee a provision to repeal the Medicare payroll tax exemption for earnings in excess of the statutory wage base. Under current law, the Medicare payroll tax is 1.45 percent for both the employee and the employer up to a maximum level of $45,000 in 1988. The Finance Committee proposal would have removed the $45,000 cap and required the 1.45 percent Medicare payroll tax be paid on all earnings. It was estimated that this proposal would raise $2.2 billion in fiscal year 1988 and $15.4 billion over 3 years. The Finance Committee argued in favor of this proposal for several reasons, including:

(1) It would begin to address the long-term solvency needs of the Medicare trust fund.

(2) It would eliminate the regressivity of the Medicare payroll tax by making the 1.45 percent rate uniform for all workers. Currently, the more a person earns in excess of the wage base, the lower his or her effective rate is.

(3) It would apply to only the most highly paid workers—those earning in excess of $45,000 in 1988. There would be no effect on the 92 percent of workers who earn less than that and a two-earner family could earn up to $90,000 without being affected.

(4) It would not repeal the wage base cap on the Social Security payroll tax. Under Medicare, all eligible beneficiaries receive the same coverage, regardless of the amount of the worker's contribution. Unlike Medicare, Social Security benefits are based on the amount of contribution. A dollar cap on the taxable wage base is more appropriate for the Social Security tax because it prevents the benefit formula from generating unduly large benefits.

Despite serious consideration, the proposal to remove the Medicare payroll tax cap was not included in the final reconciliation legislation. During the budget summit following the October stockmarket crash, the administration indicated that it would not support this tax increase. Further, many Members of Congress had been looking at this source of funding for, among other items, an expension of the Medicare long-term care benefit. In light of the opposition to this proposal from both sides of the political fence, it was not surprising that the proposal did not reach the President's desk when he signed the Omnibus Budget Reconciliation Act (OBRA) of 1987 into law.

Although not significantly addressed in 1987, the need for comprehensive Medicare reform will not disappear. There continues to be no consensus about how reform is to be achieved. However, beyond the 1987 Senate Finance Committee approach, options include tapping new sources of revenue for the trust fund such as additional premiums, an income tax surcharge to be paid by Medicare beneficiaries, dedicated additional excise taxes on tobacco and alcohol, and funds from general tax revenues. Other options propose to transform the basic mode of health care delivery to a delivery system dominated by organizations that manage the provision of health care, such as health maintenance organizations and competitive medical plans. Still others suggest that Medicare costs can be contained by cutting back coverage, by requiring a means test for eligibility, or by altering payment incentives to make providers more efficient. Whether these or other courses of action are selected as the options in the future, it appears clear that Congress and the administration cannot wait too much longer before taking steps toward comprehensive reform of the Medicare Program.

(C) ADMINISTRATION'S FISCAL YEAR 1988 BUDGET PROPOSAL

In 1987, cost containment again was translated principally into efforts to slow the increase in Medicare outlays. There are a number of strategies that can be employed to curb Medicare outlay growth, such as reducing eligibility, reducing benefits, increasing beneficiary cost-sharing, or limiting health care provider reimbursement. As in the past Reagan budgets, the Medicare budget for fiscal year 1988 incorporated all these strategies. In addition, the administration attempted to make significant changes in Medicare policy through regulation.

The administration's fiscal year 1988 budget for Medicare reflected its overall theme of curbing Government spending to reduce the Federal deficit. It also reflected the administration's long-term goal of reducing the Government's role in the provision of health services by privatizing as much of the Medicare system as possible. The President's fiscal year 1988 budget proposed $73 billion in net outlays for the Medicare Program. This figure was $10.1 billion, or 13 percent below the Congressional Budget Office's (CBO) current services estimate for fiscal year 1988. The administration proposed a number of changes in Medicare that would reduce spending by $5.1 billion in fiscal year 1988 and $52.7 billion through 1992. The additional $5 billion discrepancy is attributable to a number of factors including the differences in assumed annual growth in hospital services. In addition, general fund transfers to the Medicare trust funds would be reduced by $700 million in fiscal year 1988 by increasing the percentage of the Part B premium paid by new Medicare beneficiaries.[23]

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[23] The summaries of the fiscal year 1988 administration budget proposals rely heavily on U.S. Congress, Senate Special Committee on Aging, Proposed Fiscal Year 1988 Budget: What It Means for Older Americans. 100th Cong., 1st Sess., March 13, 1987. Washington, D.C., U.S. Govt. Print. Off., 1987.

(1) Beneficiary Proposals [24]

The administration's budget contained several proposals which would raise $900 million in new revenues in fiscal year 1988, and $17 billion from 1988 through 1992, by directly increasing individual beneficiary payments. Many of these were recycled from previous administration budgets. The proposed changes in beneficiary cost-sharing were intended to increase beneficiary contributions to the costs of care. Opponents argued that beneficiaries now are facing large out-of-pocket expenditures in connection with their medical care. In 1985, America's elderly spent on average $1,660 for health and long-term care—more than 15 percent of their already limited incomes. Indeed, 1985 marked the first year in which the elderly spent more for their health care than they did when Medicare and Medicaid began.[25]

Part B premium increase.—Under the administration's proposal, Part B monthly premiums would be increased to represent 35 percent of program costs for new enrollees and to represent 50 percent of premiums paid by third parties, such as State Medicaid programs. This proposal would reduce fiscal year 1988 outlays by $700 million and marked the first time an administration's budget proposal had distinguished between current and future enrollees. CBO estimated that new enrollees would pay more than 40 percent more than current beneficiaries, and third-party payers would pay more than double the current premium.

Delay eligibility.—Eligibility for Medicare begins on the first day of the month in which an individual reaches age 65. Once again, the administration proposed to begin Medicare eligibility on the first day of the month following the individual's 65th birthday.

This proposal, estimated to reduce outlays by $200 million in fiscal year 1988, either would shift costs to older individuals or to employer-based health insurance plans that may now cover persons up to age 65 or until they are eligible for Medicare. The administration argued that the initiative would not result in a gap in insurance coverage since nearly all employer-based plans generally extend protection until the beginning of Medicare coverage. This is questionable, however, given the many pre-Medicare eligible who find themselves with gaps in coverage, about 11 percent of the medically uninsured are age 55 to 64. Some of these people would be forced to delay access to Medicare for as much as a month.

Increase and index Part B deductible.—Enrollees in the Part B portion of Medicare must pay the first $75 of covered expenses (known as the deductible) each year before benefits are paid. The amount of the deductible is fixed by law. The administration proposed to increase the Part B deductible each year by indexing it to the medical economic index (MEI). According to the CBO, this proposal would reduce outlays by $400 million between fiscal year 1988 and fiscal year 1992 and would increase the deductible to $88 by 1992.

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[24] Ibid.

[25] U.S. Congress, House Select Committee on Aging, America's Elderly at Risk. Report presented by the Chairman, Committee Print, 99th Congress, July 1985, p. vii.

Extend Medicare as secondary payer.—The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) required employers to offer their employees aged 65–69 the same group health plan offered to their employees under 65. The Deficit Reduction Act of 1984 extended the provision to beneficiaries covered under a working spouse's employer-based health plan when that spouse is under 65. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) extended this provision to the working aged and spouses over 69. Where the beneficiary elects such coverage, Medicare becomes the secondary payer. The beneficiary, however, retains the option to be covered only by Medicare.

The administration's 1988 budget proposed to extend the secondary payer provision to disabled beneficiaries who are also covered under their own working spouse's employer-based health plan. The provision would be enforced through the use of an excise tax on employers who do not comply; it was estimated that savings would total $300 million over the 5-year budget projection period. Opponents of the plan argued that it would discourage employers from retaining disabled workers. The employer community also expressed concern that it would shift more costs for health care to the private sector.

Establish a voluntary voucher program.—The administration also proposed legislation for a Medicare voucher plan to permit beneficiaries, at their option, to seek private alternatives to Medicare coverage. Advocates for the voucher concept argued that such an approach would foster greater competition in the provision of health services to Medicare beneficiaries as well as moderate increases in health spending for the target population. Critics expressed doubts that the kinds of insurance incentives envisioned as part of such plans would in fact have much effect on either the cost or use of health services, especially among the higher risk aged and disabled population who are likely to maintain their enrollment in the basic Medicare Program.

(2) Provider Cuts

The largest part of the administration's proposed cuts in Medicare ($2.1 billion in fiscal year 1988 and $31.7 billion over the 5-year budget projection period) would come from payments to providers. Under the proposed budget, major savings would be achieved by imposing a number of changes in the way Medicare reimbursed hospitals for capital and medical education. The administration also sought a number of changes in its prompt pay and periodic interim payment policies as well as other policies that affect the flow of Medicare dollars to hospitals. In addition, it sought substantial reductions in payments to physicians and for other Part B services. Major proposals included:

Hospital payments.—Restricting the increase in prospective payments to hospitals. This proposal would save $500 million in fiscal year 1988 outlays and $17.9 billion over the 5-year projection period.

Capital costs.—The administration would change payments to hospitals for capital costs from a cost reimbursement to a prospective payment system. This proposal would be phased in and would be budget neutral until 1990. Savings from 1990 through 1992 were estimated at $2.1 billion.

Medical education.—The President's budget proposal would lower reimbursement for direct payments (such as residents' and teachers' salaries, classroom expenses, and associated overhead) and indirect payments (for such costs as the greater number of tests prescribed by interns and residents). This proposal would save $1.2 billion in fiscal 1988, but was criticized on the grounds that it would have an adverse effect on poor elderly persons who obtain low-cost health care through these medical training programs.

Periodic interim payments.—Under current law, hospitals that are designated as disproportionate share hospitals (hospitals providing a disproportionate share of low-income patients), and some rural hospitals receive Medicare periodic interim payments (PIP) every 2 weeks. This reimbursement is based on estimated annual costs and assures these hospitals a constant flow of cash.

The administration proposed eliminating PIP for disproportionate share hospitals. Although this would save $700 million in fiscal year 1988, it likely would create serious cash flow difficulties for about 300 hospitals.

Prompt payment.—The Omnibus Budget Reconciliation Act of 1986 required prompt payment of 95 percent of Part A "clean" claims (claims requiring no further substantiation) within 30 days of receipt in fiscal year 1987; 26 days in fiscal year 1988; 25 days in fiscal year 1989; and 24 days thereafter. Similar timeframes are established for Part B claims except that a shorter timeframe is established for "participating" physicians: 19 days in fiscal year 1988; 18 days in fiscal year 1989; and 17 days in fiscal year 1990.

The administration proposed to modify the OBRA 1986 provision by setting the ceiling for all claims at 30 days in fiscal year 1988 and future years. CBO estimated that this proposal would save $1.3 billion in fiscal year 1988.

Physician payments.—The administration proposed saving $10 million in 1988 and $500 million over 5 years by reimbursing radiologists, anesthesiologists, and pathologists through the prospective payment system for hospital services. In addition, the budget proposed repealing provisions of the OBRA 1986 which extended Medicare coverage to services provided by physician assistants, occupational therapists, and optometrists and which set higher dialysis reimbursement rates than proposed by the administration. Repeal of these provisions would save $400 million over 5 years, but could reduce access to these important services. The administration also proposed to pay new physicians at approximately 80 percent of the local prevailing charge. This proposal would save $700 million over 5 years.

(3) The Congressional Response

In 1987, Senator Melcher conducted an Aging Committee hearing to review the administration's proposals. During the hearing, both Senators Melcher and Heinz released staff analyses of the administration's fiscal year 1988 budget. Both reports documented the significant extent to which the President's budget cuts were aimed at programs for the elderly. Following the hearing, Senator Melcher initiated an Aging Committee letter to the chairman and ranking member of the Budget Committee, Senators Chiles and Domenici. Athough the letter covered a wide scope of issues, significant concerns were raised with regard to cuts in the Medicare Program.

Both the House and the Senate were quick to pare down the scope and magnitude of the proposed cuts in Medicare. Medicare already had absorbed about $30 million in cuts between 1981 and 1986, and as noted previously, beneficiaries were shouldering an increasingly large financial responsibility for their health care. Congress was reluctant to place additional financial burdens on the elderly by achieving Medicare cuts through cost-shifting. As in past years, the budget reductions that survived the congressional obstacle course and emerged from the 1987 budget summit (and later incorporated into OBRA 1987) were targeted at providers and not beneficiaries. The final reconciliation law included $2.1 billion in Medicare cuts for fiscal year 1988. Although these cuts were significant, they were far less substantial than the $5.1 billion in cuts that the administration had originally proposed. The major health policy issues, which were raised and/or addressed during the budget process, are outlined in the following section.

(D) MEDICARE AND THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

Medicare's fiscal year 1988 budget was considered as part of the 1988 budget resolution and then as part of the Omnibus Budget Reconciliation Act of 1987 (H.R. 3545; Public Law 100-203).

(1) Issues Affecting Medicare Beneficiaries

The Congress rejected all of the administration's proposals which would significantly affect Medicare beneficiaries. Because most of the beneficiary measures had been previously advanced by the administration, it was not surprising that Congress did not give them much serious consideration. However, two issues of particular consequence to beneficiaries stood out: The unprecedented increase in the 1988 Part B premium and Medicare beneficiary appeal rights.

(a) Medicare Part B premium increase

When Medicare was established in 1965, the Part B premium was set at an amount that would cover 50 percent of program costs. The Social Security amendments of 1972 modified this requirement to limit increases in premium amounts to the percentage increase that Social Security beneficiaries received in their cost-of-living adjustment (COLA). Because program costs increased well beyond the inflation rate on which COLA's are based, the portion of program costs covered by the premium declined to less than 25 percent by 1982. The Tax Equity and Fiscal Responsibility Act of 1982 set the premium at the level necessary to cover 25 percent of program costs through 1986. This provision subsequently was extended through 1988 by the Deficit Reduction Act of 1984.

In September 1987, the Health Care Financing Administration (HCFA) announced that the Part B monthly premium would be increased in 1988 from $17.90 to $24.80 to meet the 25 percent of program costs requirement. HCFA explained that the three factors influencing the increase were: (1) Earlier projections for 1987 expenditures and utilization (primarily related to costs associated with physician services) under Part B were too low; (2) the Part B program is projected to continue its current rate of growth; and (3) due to a surplus in the Part B trust fund, the 1986 and 1987 monthly premiums were, in effect, discounted as a result of the contingency reserve fund being drawn down.

In response, Senator Melcher held a hearing and released an Aging Committee staff report on the HCFA proposal to shed light on the reasons behind the Part B premium increase, the impact such an increase would have on beneficiaries, and options to reform the ways Medicare reimburses physicians. Testimony presented generally confirmed that HCFA projections, on which the premium increase was based, were accurate. However, aging advocate groups indicated that increasing burdens on Medicare beneficiaries would be particularly burdensome to low-income elderly. Further, as Senator Melcher pointed out, many beneficiaries might not be able to afford both the Part B premium increase and future, new catastrophic premiums.

Subsequent to this hearing, an attempt was made by Senator Melcher to offer an amendment to the budget reconciliation legislation which would have reduced the Part B premium increase proposed by HCFA by $2.40 a month. However, this amendment, due to the very strict Budget Act amending rules, was subject to a point of order and Senator Melcher withdrew his amendment. Even more disappointing, the Senate and House conferees on the reconciliation legislation subsequently concluded that there was no room in the budget for any Part B premium reduction. This conclusion was based on the fact that the premium increase already had been announced and, to some degree, was expected, and on the belief that continuing pressures to control Federal deficit spending precluded any change in the premium. Thus, the final reconciliation legislation (OBRA 1987) extended through 1989 the requirement that beneficiary premiums cover 25 percent of program costs.

There is little doubt that the issue of future Part B increases and physician payment reform will emerge during the second session of the 100th Congress. The numerous problems surrounding reimbursement to physicians are outlined in a following section on issues affecting physicians.

(b) Quality of care: Administrative Law Judge appeal rights

Since the enactment of the Medicare Program in 1965, beneficiaries who feel that Medicare (through the insurance carrier contracted out by the Federal Government) has not provided appropriate reimbursement for a Medicare Part B covered service have been entitled to appeal only to a hearing officer hired by the insurance carrier. In contrast, Part A claimants have the right to an appeals hearing before a Social Security Administrative Law Judge (ALJ). OBRA of 1986 partially remedied this discrepancy by providing for ALJ hearings for Part B Medicare beneficiaries where the amount at issue is greater than $500.

HCFA, in implementing the 1986 reconciliation law, required that the Part B beneficiaries complete the carrier hearing before they could request an ALJ hearing. In addition, HCFA also proposed to establish a separate law judge corps to be headquartered in Baltimore to hear the appeals of Part B, and eventually Part A, beneficiaries by telephone.

In 1987, concerns were raised in Congress regarding the effect of the HCFA proposal on due process rights of Medicare beneficiaries. Specifically, fears were raised about how well the rights of beneficiaries could be protected over the telephone. Many aging advocates felt that beneficiaries would be intimidated by phone call reviews and that important information necessary for a fair ruling might be left out during the process. In addition, it was feared that a new ALJ corps, under HCFA's jurisdiction, would be subject to internal pressures not to overturn denials.

To address this situation, Senator Melcher joined Senator Sasser in introducing S. 1857, the Medicare Appeal Rights Preservation Act of 1987. The provisions of this legislation, which require that the hearings continue to be conducted by administrative law judges of the Social Security Administration until the Secretary of Health and Human Services and the Comptroller General each conduct a study on telephone hearings and file a report to Congress, were incorporated into OBRA 1987, Public Law 100-203. The studies are to focus on whether telephone hearings allow for a full and fair evidentiary hearing and to examine other possible improvements to the hearing process.

(2) Issues Affecting Home Health Care

During 1987, there was growing concern that the Medicare home care benefit did not provide adequate post-hospital care to many Medicare beneficiaries. This problem had been exacerbated by the efforts of the Health Care Financing Administration to reduce access to the Medicare home care benefit. At the same time, concerns were raised about the quality of home health care and the adequacy of the current oversight and monitoring system to assess quality care.

(a) Inadequate access to post-hospital care

In 1983, Medicare changed the method for paying hospitals from a pay-as-you-go system to a prospective payment system based on predetermined rates for specific diagnosis-related groups. Since then, Medicare patients have been sent home from the hospital after shorter stays and in greater need of follow-up health care. At the same time, HCFA has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. As a result, more Medicare beneficiaries need home health care at a time when less care is available.

Large numbers of Medicare patients who are discharged "quicker and sicker" often find post-hospital care unavailable or substandard. The stress on post-hospital services is increasing substantially. In addition, existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS with the result that Medicare patients often received inadequate post-hospital care.

Results of a committee investigation confirmed HCFA internal reports of nearly a 40-percent increase in discharges to skilled nursing and home health care since 1983. However, home health and nursing home care in the community is often unavailable. Testimony at an earlier hearing of the committee showed that this shortage is aggravated by widespread illegal discrimination against Medicare and Medicaid eligible patients. Nursing homes prefer to take patients who will pay higher private rates as well as patients whose conditions are less costly to care for.

Adding to the problem is the fact that HCFA has sought to reduce nursing home and home health care utilization through administrative denials of reimbursement. Two hearings conducted by the Senate Aging Committee in 1986 found that while increasing numbers of seriously ill Medicare patients are in need of home health care, home health care denials nearly have tripled since the first quarter of 1983 when PPS was initiated. During this period, the rate of growth in home health services slowed—Medicare-covered visits rose an average of 19 percent from 1980 to 1983, but only rose 8 percent in 1984 and actually declined 2 percent in 1985. The committee concluded that Government policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers, resulted in reduced access to home health care for older Americans.

Finally, HCFA's use of unwritten and unpublished guidelines further limit the Medicare home health benefit. HCFA repeatedly attempted to eliminate the "waiver of liability" which gives home health agencies critical flexibility in interpreting Medicare rules and regulations so they are not forced to deny access in cases where eligibility is in question. In addition, HCFA placed limits on home health providers' abilities to appeal decisions denying Medicare beneficaries home health care and has made it very difficult for Medicare beneficiaries to appeal decisions themselves.

Many of the problems surrounding HCFA's administration of the home health benefit were outlined in the General Accounting Office (GAO) report, "The Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs." The report, requested by Senator Heinz, concluded that hundreds of thousands of chronically ill older Americans are not receiving the home health assistance they need under the Medicare Program.

GAO attributed much of the problem of inappropriate denials, as well as program abuse, to vague coverage criteria. The report pointed out that, despite a 1981 recommendation by GAO, HCFA has not clarified coverage criteria relating to frequency of care, homebound status, or provided enough training on how to interpret existing criteria.

The GAO report identified internal weaknesses in administering the home health services and estimated these weaknesses cost the taxpayer almost $600 million in improper payments in fiscal year 1984. The report goes on to say that savings realized through improved program controls, such as those recommended in 1981, could be used to provide benefits to those not currently served.

In response, Senators Bradley, Heinz, Pryor, Glenn, Melcher, and others introduced S. 1076, the Medicare Home Care Services Improvement Act. In addition, Senator Heinz introduced S. 1762, the Medicare Access Protection Act. OBRA 1987 included many of the provisions of S. 1076 and S. 1762 which were aimed at improving the Medicare home care benefit. The key provisions affecting home care included in OBRA 1987:

> *Publications of policies.*—HCFA must promulgate regulations on any new policies that change the legal standard governing benefits and eligibility for Medicare coverage. HCFA must also make available to the public all interpretive materials, guidelines, and clarifications of policies related to Medicare payments for home health and other post-hospital care. In addition, HCFA must publish at least every 3 months a list indicating the subject matter of health coverage instructions including interpretive rules, statements of policy, and policy changes. HCFA must ensure that the practices of fiscal intermediaries and carriers are consistent and clearly understood by service providers as well as beneficiaries and the fiscal intermediaries have mechanisms for consultation with representatives of health and skilled nursing home providers and consumers in their region regarding problems of claim review and coverage guidelines.
>
> *Denials.*—HCFA's fiscal intermediaries must give to the home care provider and beneficiary a written explanation of any denial of a claim for home health or SNF services, including the statutory and regulatory basis for the denial. In evaluating the performance of fiscal intermediaries and carriers, HCFA must take into account their ability to process reconsideration determinations in a timely matter and the rate at which determinations are reversed.
>
> *Homebound definition.*—OBRA 1987 clarifies the homebound definition to ensure that an individual does not actually have to be bedridden to be considered homebound. The Medicare beneficiary will meet the definition of homebound if he or she has a condition, due to an illness or injury, that restricts the ability to leave home except with the aid of a supporting device or that the individual has a condition such that leaving home is medically contraindicated.
>
> *Home health prospective payment.*—HCFA must conduct a study and demonstration of alternative methods for paying home health agencies under Medicare on a prospective basis. These methods must include payments on a per visit, per case, and per episode basis. The demonstration must consider the effects of these methods on access and quality of care.

(b) Quality of home health care

Very little attention from the Federal level has focused on the quality of care that home care agencies provide. The evaluation of quality of care by HCFA has focused on the home care agency's organizational form, the facilities and equipment, its staff's credentials, and its fiscal management. These standards tend to measure an agency's capacity to deliver services rather than the quality of the services actually provided.

In 1987, the Senate Aging Committee held two hearings to examine the quality of home care provided to older Americans. The committee focused on four major problems surrounding home care: (1) Training and supervision, (2) limited access to services—including barriers created by Federal programs such as Medicare, (3) lack of consumer protection and involvement, and (4) lack of national standards for quality assurance. The committee is expected to release a report on the status of in-home care early in 1988.

At the time of the first hearing, the Office of the Inspector General (OIG) of the Department of Health and Human Services released the findings of a study that raised concerns about the overall quality of care provided by home-health aides. The report also noted that recruitment, hiring, and retention of home-health aides due to low pay and limited benefits are major problems. In addition, the committee reviewed a study by the National League of Nursing that found many home health aides seriously deficient. Findings included: 44 percent of the aides could not read a thermometer, 30 percent do not know what to do if a patient stops breathing, and 46 percent do not know how to properly monitor a patient's fluid intake.

During both hearings, Aging Committee members severely criticized HCFA for not implementing a 1980 congressional mandate for a home-health aide training program prior to providing services. Subsequently, Senator Melcher requested DHHS Secretary Bowen to direct HCFA to take immediate action toward promulgating regulations for training programs as required in the Omnibus Budget Reconciliation Act of 1980. However, at the end of 1987, no significant action by DHHS had taken place.

Several important quality assurance provisions were included in the Omnibus Budget Reconciliation Act of 1987. The key provisions:

> *Tougher survey and certification process.*—HCFA must establish a revised certification survey that focuses on the quality of patient care and the effect of that care on the patient. This ensures that the capacity to deliver care actually translated into the provision of high quality care. Rights for home care consumers are clearly delineated and quality monitoring surveys of home care agencies will be conducted annually and unannounced. Intermediate sanctions for poor quality also are established, including civil fines and denial of Medicare reimbursement for future Medicare patients. Finally, employees of home care agencies, including home health aides, would be required to meet approved training standards.
>
> *Home health hotline and investigative unit.*—All State agencies that certify home health agencies for participation in Medicare must collect certain information on Medicare-certified agencies, including significant deficiencies relating to patient care, corrective actions taken, and sanctions imposed. Agreements must also provide for a toll-free hotline to receive complaints and answer questions with regard to home health agencies and for a unit to investigate these complaints. The unit

will have enforcement authority and access to survey reports and consumer medical records.

As the elderly population increases, so too will the need for quality home care. The Aging Committee will continue to monitor the performance of DHHS in this area to make certain this need is met.

(3) Issues Affecting Hospitals

In 1987, as in previous years, Medicare hospital payments became a major target for budget cutting efforts as the Congress sought to meet the deficit reduction targets of the Gramm-Rudman-Hollings law. This fact, combined with efforts to refine the Medicare hospital prospective payment system, created a challenging setting within which the Congress and the administration sought to resolve health policy and deficit reduction demands. Throughout the budget debate, priority was placed on consideration of the special needs of rural hospitals, and in preserving the largest possible hospital payment update within the tight budget constraints.

(a) Quality of care issues/peer review organizations

When Congress enacted Public Law 98-21 establishing Medicare's PPS, there was a general recognition that inherent in the newly structured payment system were incentives to underserve patients and discharge patients prematurely. To ensure against these outcomes, Congress charged peer review organizations (PRO's) with monitoring quality of care as well as utilization outcomes.

Nevertheless, PPS incentives to reduce costs and thus services were strong enough to raise fears that the health or lives of some Medicare beneficiaries might be endangered. After a year of implementation, many physicians and consumer groups representing the elderly began to grow concerned that PPS was posing serious threats to quality for care of Medicare beneficiaries, and might be eroding access to care for the sickest and oldest beneficiaries.

Since implementation of PPS, the Senate Special Committee on Aging has been actively involved in investigating problems regarding the delivery of quality health care under Medicare. The committee's efforts uncovered serious deficiencies related to earlier hospital discharges, denial of access to needed services, inadequate rights of appeal, pressures on physicians to provide care at a lower level than that which would be considered sound medical practice, limited focus of PRO activities, inadequate post-hospital care, and the lack of adequate data regarding the quality of health care provided under PPS. Related committee activities uncovered serious limitations on the part of the Federal Government to protect beneficiaries from incompetent and dangerous medical practitioners. The findings of former Aging Committee Chairman Heinz led him to develop legislation to ensure better quality care under PPS and to safeguard against unfit health care practitioners.

As part of OBRA 1986, the Congress enacted a number of quality of care reforms. Among the new reforms enacted were the written notice to patients of hospital discharge rights, an improved discharge planning process, a study of payments for administratively necessary days, allowance for provider representation of beneficiaries during certain benefit appeals, and a number of PRO improvements including the requirement that PRO's review the quality of care provided.

In the final days of the 99th Congress, the House and the Senate attempted to enact additional quality of care and antifraud changes included in S. 837/H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act. However, despite efforts by the bill's sponsors, Senators Heinz and Glenn, the abbreviated election-year legislative session provided insufficient time to complete action on the measure. However, the legislation was reintroduced in 1987 and was signed into Public Law 100-93 on August 18, 1987.

The new law mandatorily excluded from participation in Medicare, the Medicaid, Maternal and Child Health Block Grant, and the Social Services Block Grant any medical practitioner (whether an individual or entity) convicted of a criminal offense for neglect or abuse of a patient in connection with the delivery of a health care item or service or a ciriminal offense relating to delivery of a service under Medicare or a State health care program. Among its other provisions, the law specifies a number of circumstances under which the Secretary of DHHS is granted the discretion to exclude providers from participation in State and Federal health care programs, makes provisions for the duration and appeal of such exclusions, allows for civil monetary and criminal penalties, and requires States to develop a system for maintaining statistics on and reporting of action taken against sanctioned providers.

During 1987, there was continued congressional interest in the PRO system and its objective of ensuring the delivery of quality health care. Of particular concern to the Congress were PRO funding adequacy, contracting procedures, and the denial and provider sanctioning procedures.

OBRA 1987 included a number of changes affecting contracting and other aspects of the PRO system. Specifically, the final legislation extends initial and renewal PRO contract periods from 2 years to 3 years, and allows the Secretary of DHHS to stagger the contract renewal periods. These changes are expected to foster greater stability in PRO operations, allow for more accurate evaluation of a PRO's performance, and reduce administrative contracting costs. In addition, the new law requires that each PRO offer educational sessions several times each year to hospital staffs regarding review of the hospital's Medicare services, directs PRO's (to the extent possible) to provide initial review of psychiatric and physical rehabilitation services by a physician trained in the appropriate field, and requires PRO's to consider special problems of delivering care in remote rural areas.

Also included in the OBRA 1987 were PRO provisions which require that: (1) PRO's provide reasonable notice and opportunity for discussion of denied claims and that the provider be given 20 days (for discussion and review) before the payment denial would be effective, (2) the DHHS Secretary publish in the Federal Register (30 days before the date on which the change takes effect) any new policy or procedure that affects the performance of PRO contract obligations, (3) general criteria and standards used in evaluating

PRO fulfillment of contract obligations be published in the Federal Register, and (4) the Secretary of DHHS provide documentation to each PRO on its performance in relation to other PRO's.

Finally, another major development in the area of quality assurance emerged from last-minute negotiations between the Senate Finance Committee and OMB over the level of funding and scope of work for PRO's. In response to growing frustration with OMB's failure to fully fund PRO's and to comply with a Congressional mandate to extend PRO review to non-hospital settings, the Finance Committee supported an amendment offered by Senator Heinz that would prohibit OMB from limiting funds for PRO's. OMB strongly opposed this provision and, in exchange for removing the provision from the reconciliation measure, OMB Director James Miller agreed to double the funding of PRO's and to begin moving PRO quality review into nursing homes, home health care, and physician's offices.

(b) Rural health care

Access to adequate, appropriate health care services in rural areas was one of the major health care issues of 1987. Rural hospitals are perceived by many health policy analysts to have a special set of problems that make them more vulnerable to experiencing significantly greater financial problems. Some of the problems may be related to cost containment and other changes that have come along with the implementation of Medicare's prospective payment system. Other problems have arisen due to adverse economic conditions in rural areas. These problems include fewer hospital admissions, declining lengths of stay, and increasing severity of illness of the patients who are admitted to hospitals. In addition, these hospitals have fewer personnel and specialized services, lower overall occupancy rates, and serve a population more likely to be underinsured as well as older than average. As a result of these differences, many experts believe these hospitals have been more vulnerable to recent Federal health cost containment policies.

There is considerable debate among health policy experts whether steps should be taken by the Federal Government to prevent the closing of rural hospitals, especially those which are the sole providers in their area. While such hospitals may not be economically efficient, they often play a role in the community that goes beyond the provision of inpatient hospital services. They are often the single largest employer in the area and they help to attract primary care physicians who want to be assured that they have access to necessary specialized equipment and staff. In some areas of the United States, the small rural hospital provides the only health care in the area. In these cases, potential patients would be forced to travel long distances to obtain medical care if the local hospital were closed.

To remain financially viable, some rural hospitals are attempting to diversify their services to generate new revenues. A popular strategy is to convert a number of beds to post-acute beds and to offer home care and social services. Other hospitals are entering into multihospital arrangements to help ease their financial strains. These arrangements can include affiliations, shared services, consortium arrangements, contract management, leases, corporate ownership with separate management, and complete ownership. The advantages of joining such arrangements include cost savings from joint purchasing and shared services, certain operating advantages such as increased productivity and lower staffing requirements, and improved access to capital resulting in lower interest costs.[26]

There are a number of features of PPS which have been identified as having an effect on rural hospitals, including the urban/rural DRG payment differential, the wage index adjustment, payments for outlier cases, and the special provisions for sole community providers, referral centers, and hospitals serving a disproportionate share of the poor patients.

Of primary importance to all hospitals (and particularly rural hospitals) has been the amount of increase Congress authorizes to PPS hospitals. This increase, known as the update factor, is discussed in greater detail in the next section. However, a number of other important provisions were included in the final OBRA 1987 package which address congressional concerns with regard to rural hospitals. These provisions include: (1) Developing an Office of Rural Health Policy to coordinate departmental initiatives related to rural health care, to assess the impact of departmental rules on rural health care delivery, and to establish a clearinghouse for information related to rural health care, (2) establishing a grant program for small, rural, private, not-for-profit hospitals to provide assistance in altering their health care delivery practices to respond to changing rural health care needs, (3) expanding the rural swing-bed program to include certain hospitals with up to 100 beds, (4) clarifying eligibility for payment adjustments to compensate for a significant decline in the volume of admission for hospitals which meet the criteria and definition of sole community provider, (5) modifying the rural referral center criteria, (6) revising the standards for including certain rural counties in adjacent urban areas, (7) requiring a Prospective Payment Assessment Commission (ProPAC) study of eliminating or phasing out the separate urban and rural payment rates (as well as of the desirability of maintaining separate rates for large urban and other urban hospitals), (8) requiring the Secretary of DHHS to conduct a survey of and to revise the Medicare hospital wage indices by October 1, 1989, and every 3 years thereafter, and (9) requiring the Secretary of DDHS to set aside at least 10 percent of departmental demonstration funding for projects related to rural health.

(c) Transition to national rates and increasing DRG payments

Prior to PPS, hospitals were reimbursed for services by Medicare based on the costs the individual hospital incurred in the delivery of such services. Under PPS, a set payment rate (based on the physician's diagnosis) is paid to the hospital. During the initial 4-year phase-in period, PPS rates were to be based in part on historical, hospital-specific costs and in part on a Federal prospective rate.

During 1986, transition to a fully phased-in national DRG payment rate was delayed until 1987. Because of delays during 1987 in final disposition of the fiscal year 1988 budget (and under threat of a Gramm-Rudman-Hollings reduction of 2 percent in Medicare payments) the Congress froze hospital PPS rates at the fiscal year 1987 level from October 1, 1987 through November 20, 1987 (under the debt limit extension act, Public Law 100–119). This measure allowed Congress some additional time to act on a budget measure. The legislation also delayed the PPS transition to fully prospective, national rates for 51 days, and required that all Medicare payments to hospitals made on or after November 21, 1987, would be reduced by 2.324 percent (Medicare's share of the Gramm-Rudman-Hollings deficit reduction provisions). However, on November 21, 1987, the scheduled 2.7 percent rate increase mandated by Public Law 99–509 also took effect. This increase will continue to apply until March 31, 1988.

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[26] Rural Hospitals and Medicare's Prospective Payment System, Background Paper, Prepared for the Use of the Members of the Committee on Finance, May 1986.

Because hospital payments comprise such a large share of the Medicare Program, they were again the major focus of congressional efforts to trim Medicare in 1987. However, authorizing committees, senstive to the growing financial concerns of hospitals (particularly rural hospitals), tried to provide as large a PPS update factor as possible for hospital payments. In addition, in an attempt to increase rural hospital reimbursement by Medicare, many Members actively supported efforts to equalize payment increases between urban and rural rates.

The final budget package included a payment update effective for discharges on or after Aptil 1, 1988, of 1.5 percent for hospitals in large urban areas, 3 percent for hospitals in rural areas, 2.7 percent for PPS-exempt hospitals, and 1 percent for other hospitals (those in smaller urban areas of less than 1 million population). The legislation also established regional hospital payment floors and required a study (due in 1989) by the Prospective Payment Assessment Commission (ProPAC) on nonlabor costs and adjustments for variations in input prices among hospitals.

(d) Capital reform

Under current law, hospitals are reimbursed on a retrospective cost basis for their expenditures for equipment and facilities, including rental, interest, insurance, and depreciation costs, and a return on equity. The passthrough of capital costs has encouraged hospitals to make capital investments, whether or not those investments are justified in terms of the needs of their communities. Moreover, as ProPAC has noted, the passthrough encourages early retirement of assets, promotes insensitivity to interest rates and financing methods, and favors the use of capital over labor resources. In 1984, Medicare paid about $3.2 billion for capital-related costs.

In establishing PPS with the enactment of the Social Security Amendments of 1983 (Public Law 98–21), Congress deferred action on incorporating capital-related costs until 1986. This delay reflected a recognition that further study was necessary before these costs could be incorporated under PPS. Under Public Law 98–21, however, Congress also provided that if capital was not brought under PPS by October 1, 1986, all States would have to review hospital capital expenses under the section 1122 program. (This date was later moved back to October 1, 1987, with the enactment of Public Law 99–349, the Urgent Supplemental Appropriations Act.)

The Social Security Amendments of 1983 directed the administration to report to Congress on capital payment options in 1984 although the report was not delivered to the Congress until 1986. The report outlined trends in hospital capital investment, discussed practices and problems with Medicare reimbursement for capital as well as other Federal policies affecting capital payments, and detailed a number of options and recommendations for capital payment reform.

During 1986, the appropriate method for folding capital into the PPS rates was a hotly contested issue. The administration advocated a 4-year phase-in period and the use of 1983 cost reporting data. The Congress and ProPAC examined alternative strategies which included a longer phase-in. There was no final resolution to the debate, and the budget measure for fiscal year 1987 postponed disposition of the matter until the next budget cycle. However, OBRA 1986 did include reductions in cost-based capital reimbursement of 3.5 percent in fiscal year 1987, 7 percent in fiscal year 1988, and 10 percent in fiscal year 1989, and prohibited the Secretary of DHHS from making regulatory changes in this area prior to September 1, 1987. On September 1, 1987, DHHS issued a final rule regarding prospective payments for capital which established separate urban and rural rates for fixed and moveable equipment to be phased in over 10 years for fixed capital and 8 years for moveable equipment. The rates would be based on updated capital-related costs for fiscal year 1984. In the early years rates would be heavily weighted toward the hospital-specific portion. The 1987 reduction (3.5 percent) was extended through November 20, 1987 under Public Law 100–119, as was the prohibition against regulatory changes in this area.

The 1987 budget debate brought no greater clarification of the appropriate manner for PPS payment of capital-related costs. OBRA 1987 included further reductions in the cost-based payments for capital: 12 percent for fiscal year 1988 and 15 percent for fiscal year 1989. The legislation also specified requires the Secretary to include capital-related costs in the DRG payment rates beginning in fiscal year 1992.

(e) Periodic interim payment (PIP)/prompt pay issues

Those who provide services to Medicare beneficiaries are reimbursed through fiscal intermediaries and carriers. These entities—usually insurance companies such as Blue Cross and Blue Shield—contract with Medicare to handle claims processing, auditing, payment safeguards, and other such responsibilities. Congress approves an annual budget for HCFA to administer the Medicare Program which includes within it funds for the carriers and fiscal intermediaries. In recent years, the administrative budget has been tightly controlled as part of efforts to hold down Medicare expenditures.

In response to this situation, Medicare contractors reduced service levels to providers and beneficiaries, claiming that they were receiving inadequate payment to perform the increasing volume and scope of work. Consequently, it is taking more time to process claims and to respond to inquiries.

During 1986, DHHS took steps to institutionalize a slow-down in the processing of Medicare payments with the intention of making significant savings in the health care program. Medicare contractors, providers, and Members of Congress responded with vehement opposition to the proposal and the Department recanted. However, the final budget action for fiscal year 1987 included a provision which set minimum standards for timeliness of claims processing: 95 percent of clean claims in fiscal year 1987 were to be paid in not more than 30 days, reduced to 26, 25, and 24 days in subsequent fiscal years.

Prior to fiscal year 1987, DHHS regulations allowed for biweekly periodic interim payments (PIP) to providers. These payments were based on the providers projected annual costs divided into 26 equal amounts. Hospitals, home health agencies, and skilled nursing facilities meeting certain criteria were entitled to receive payments on this basis. Under legislative action during 1986, PIP was eliminated for all PPS hospitals with the exception of rural hospitals of 100 beds or less and certain disproportionate share share hospitals (hospitals which have a disproportionate share of low income patients). PIP was to be continued in cases where a hospital could demonstrate it was experiencing significant cash-flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

OBRA 1987 included several changes in claims processing. As an alternative to achieving deficit reduction savings through lengthening the Medicare claim payment process (as recommended by House budget action), the law instead set a "payment floor"—an initial processing period during which claims must be held without payment (a proposal forwarded by the Senate). The payment floor was set at 10 days for the 3-month period beginning July 1, 1988, and 14 days for 1 year beginning October 1, 1988. The legislation prohibits the Secretary of DHHS from taking other steps with the specific goal of slowing claims processing or delaying claims payments.

In another attempt to reduce the deficit, the Senate proposed elimination of PIP for disproportionate share hospitals. However, this proposal was dropped in the joint Senate/House conference and not included in the OBRA 1987. This proposal may well emerge again in 1988, however, as deficit reduction pressures continue to mount.

(f) Medical education

Since its enactment in 1965, Medicare has reimbursed hospitals for its share of the direct costs of approved health professions education programs conducted in hospitals. These direct costs include: (1) Salaries and fringe benefits for residents, faculty, and support staff, (2) the cost of conference and classroom space in the hospital, (3) any costs of additional equipment and supplies, and (4) allocated overhead costs. Physician graduate medical education (residency training) is the most costly component of health professions education paid under Medicare.[27] In addition, Medicare pays teaching hospitals an additional amount, called the indirect adjustment, to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals than in nonteaching hospitals.

When the Medicare Program was established, Congress made clear its intent that Medicare should support the clinical training of health personnel at least until alternative community-based systems of support were developed. As a result of Medicare payment policies as well as additional Federal support of the health professions through the National Institutes of Health and Title VII of the Public Health Service Act, a vast network or medical and health profession schools developed throughout the country.

The resulting growth in medical education has helped ease what was once a substantial physician shortage to the point where many now argue that we are in danger of having too many physicians by the end of the decade. According to a report by the Graduate Medical Education National Advisory Committee (GMENAC) published in 1980, there will be 70,000 excess physicians by 1990 and 145,000 excess physicians by 2000. A 1984 study by DHHS has predicted an excess of more than 35,000 physicians by 1990 and about 51,000 by 2000. However, while in the aggregate there may be an excessive amount of physicians, a physician shortage is expected to exist for certain specialty areas such as psychiatry and primary care specialists.

There is also evidence that there remain a large number of medically underserved areas in the Nation, indicating that excess supply does not directly alleviate maldistribution problems, especially in poor inner-city neighborhoods and remote rural area. The DHHS and GMENAC reports also reinforce growing concerns about the appropriateness of continued Medicare funding for foreign medical graduates (FMG's). On the one hand, FMG's have helped alleviate shortages in some geographical areas; on the other hand, they are viewed as feeding the physician glut.

Under the 1983 PPS legislation, Congress doubled the indirect medical education adjustment in order to counteract the potential negative impact that PPS was expected to have on teaching hospitals. Within a few years, claims were made that reimbursement for both direct and indirect medical education under Medicare was excessive, and that reductions were warranted. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Congress established a PPS for the direct costs of medical education. Payment is based on each hospital's average cost per resident and on the number of years of training provided to residents. COBRA also reduced the indirect medical education adjustment factor to approximately 8.1 percent from May 1, 1986, to October 1, 1988. This adjustment is applied on a curvilinear basis, meaning the payment would not necessarily increase in direct proportion to the ratio of interns and residents to bed size. The Congress also provided for a temporary adjustment for hospitals with large percentages of low-income Medicare and Medicaid patients. This adjustment was financed by the reduction in the teaching adjustment. When the disproportionate share adjustment expires on October 1, 1988, the indirect teaching adjustment would increase to 8.7 percent.

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[27] U.S. Library of Congress, Congressional Research Service, Background Paper for use of the Members of the Senate Finance Committee on Payments for Medical Education by the Medicare Program. Washington, DC, May 1985.

The primary related development in OBRA 1986 was a provision which reimbursed under Medicare all the time a resident spends in patient care activities, regardless of the setting. This change encourages training in primary and long-term care, and eliminates the disincentive to train in certain outpatient settings.

To further control costs and reduce the Federal deficit, OBRA 1987 reduced the indirect medical education adjustment to approximately 7.7 percent. This reduction takes effect on October 1, 1988. Although the Senate recommended further reductions in direct education payments for FMG's, this provision was dropped in the joint Senate/House conference and the final budget legislation did not include this change. OBRA 1987 also extended the disproportionate share adjustment to October 1, 1990.

(g) Uncompensated care

Traditionally, the public-private patchwork of health insurance coverage has afforded basic protection to a majority of Americans. However, today there are 37 million Americans who find themselves without health insurance. Approximately 17.1 percent of the population under 65 is uninsured. Of these, 5.5 million are 45–54 and 2.9 million are 55–64. Surprisingly, even 389,000 persons over the age of 65 are without insurance of any kind even though the common perception is that all the elderly are taken care of by Medicare and Medicaid.[28]

The number and proportion of the uninsured is increasing substantially. The number of uninsured non-aged persons, the only group for which trend data are currently available, increased by 20.4 percent from 1979 to 1983.

Prior to the last recession, the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time, or low-skilled jobs, in which employers generally did not provide health insurance coverage. Most working Americans received health insurance through their or their spouse's employer. Others were protected by public insurance programs or their costs were picked up by health care providers who subsidized nonpaying patients by shifting the costs for these "bad debts" and "uncompensated care" patients to other payers.

During the last recession, 10.7 million Americans lost their health insurance. These people lost this vital protection when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Cutbacks in Medicaid and other public programs have reduced some of the sources of funding which formerly helped to subsidize health care for America's uninsured. In addition, the changing nature of the better care market, with reforms in reimbursement, heightened competition and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured to obtain even emergency access to health care.

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[28] U.S. Congress, Senate Special Committee on Aging, Americans at Risk: The Case of the Medically Uninsured. Background paper prepared by the staff. Washington, D.C., June 27, 1985.

Before prospective payment, many hospitals were able to shift the burden of providing high levels of uncompensated care to Medicare and other payers, such as Blue Cross. Under PPS and the threatened ratcheting down of Federal payments, as well as tightening reimbursement policies among private payers, hospitals, are increasingly reluctant to take patients for whom there is no guarantee of reimbursement. The shrinking number of hospitals that take large numbers of low-income patients argue that such patients are generally sicker and require greater intensity of services. To the extent that these hospitals are bearing a disproportionate burden of such patients, they assert that they should be receiving a reimbursement which reflects this special burden.

Disproportionate share hospitals.—Legislation addressing disproportionate share hospitals (DSH's) was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982. The Secretary of DHHS was required to provide for exemptions from, and adjustments to, the cost limits then in effect for Medicare reimbursement to hospitals. HCFA did not implement the provision because, as was indicated in regulations, it did not have the data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. A similar provision for DSH's was included in the Social Security Act Amendments of 1983. Under this act, the Secretary was charged with developing a methodology for a DSH adjustment to the DRG's. Again, HCFA indicated in regulations that it would not implement the provision in fiscal year 1984 or fiscal year 1985 because it did not beleive that it had the evidence to justify the adjustment. In Public Law 98-369 (the Deficit Reduction Act of 1984), Congress required the Secretary to develop a definition of disproportionate share hospitals and to identify such hospitals by the end of 1984, which it failed to do.

The special needs of DSH's have been the subject of much debate and have greatly influenced congressional action on a number of issues related to Medicare hospital reimbursement. Special needs could be interpreted to include a broad array of specific problems found in hospitals serving low-income or Medicare patients, ranging from potentially higher costs of treating patients that are more severely ill to the cost of providing uncompensated care. Generally, they have been interpreted more narrowly. Thus, the costs of additional services and more costly services that may be required to meet the needs of low-income or Medicare patients would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, additional payments to hospitals under Medicare for such costs as uncompensated care have been excluded, usually on the grounds that Section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the costs of services provided to persons not entitled to benefits under the program.[29]

In 1985, PROPAC recommended that a DSH provision be included in fiscal year 1986 PPS rates.[30] Armed with this recommendation, and frustrated by HCFA's inaction, the House Ways and Means Committee decided to develop its own adjustment, and included a provision in its deficit reduction package. In response to a court order from the U.S. District Court for the Northern District of California, resulting from the lawsuit of a small California rural hospital, HCFA published proposed rules implementing a DSH provision on July 1, 1985. However, HCFA made clear that it would award such an adjustment only in extraordinary cases and only after a case-by-case review.

The 1985 budget reconciliation package (OBRA) required that the disproportionate share adjustment be applied to the Federal portion of the DRG rate for hospitals with a relatively high percentage of low-income patients. Urban hopsitals with at least 100 beds receive a graduated adjustment from 2.5 to 15 percent, if their disproportionate patient percentage is at least 15 percent. Smaller urban hospitals receive an adjustment of 5 percent if their disproportionate patient percentage is at least 40 percent. Rural hospitals receive an adjustment of 4 percent if their disproportionate patient percentage is at least 45 percent. The adjustment applies to all discharges after April 30, 1986, and before October 1, 1988. Under OBRA 1987 (Public Law 99-509), the adjustment was extended to all discharges before October 1, 1990.

During the 1987 budget debate, members of authorizing committees of Congress once again expressed concern about DHHS delays in implementing the DSH adjustment for hospitals receiving more than 30 percent of net patient revenues from State and local government programs, and increased the limit on the disproportionate share adjustment for these hospitals meeting the State and local indigent care revenue test from 15 percent to 25 percent. This change provides increased revenues to those hospitals serving the most significant low-income Medicare populations, providing them more equitable DSH payments.

(h) Area wage index

The area wage index is an important element used in the calculation of DRG payments to hospitals. The wage index was developed to ensure that the DRG payments reflect differences in wages from area to area. To compute the initial wage index, HCFA used hospital wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the Department of Labor. However, it is generally recognized that this data base does not accurately reflect differences among hospitals. The principal limitation of the BLS data—their inability to recognize local differences in the number of part-time workers—was cited by a large number of hospitals, particularly rural midwestern facilities.[31] Under the Deficit Reduction Act of 1984, HCFA was required to report to Congress on a refined wage index which was to be implemented retroactive to October 1983. In 1984, HCFA attempted to obtain better data on wage differences through a survey of hospitals, but the survey was hampered by a low response rate and questionable data quality.

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[29] U.S. Library of Congress, Congressional Research Service. Medicare Payment Provisions for Disproportionate Share Hospitals. Background Paper. Prepared for the use of the Members of the Committee on Finance, Washington, D.C., July 1985.

[30] U.S. Dept. of Health and Human Services, Prospective Payment Assessment Commission, Report and Recommendations to the Secretary. Washington, D.C., April 1, 1985.

The required report, [32] which was released to Congress in 1985, proposed two alternatives. One wage index was derived from total gross hospital wages, which included salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers and hospital-based physicians. The other index excluded several variables from its calculation and was referred to as the adjusted gross index. Later that year, HCFA implemented a new wage index for discharges based on the gross wage data from HCFA's 1984 survey. The rule also provided that the retroactivity required by current law would not come into effect until 1986. This was done to allow time for Congress to reverse the retroactive provision and for HCFA to develop a method to identify retroactive amounts.

In 1986, HCFA implemented a revised wage index, based on 1982 HCFA data which reflected the total hours of employment rather than the number of employees. This wage index was continued into 1987 with minor changes.

In 1987, ProPAC recommended that the Secretary of DHHS update the hospital wage data on a regular basis in order to ensure the most accurate wage index possible, and that the data include wage and hour employment information for hospital occupational categories.[33] In September 1987, the HCFA published final rules for the Medicare inpatient hospital prospective payment system for fiscal year 1988 which changed the method of computing the national average wage level for use in determining the area wage index. In addition, the regulations adopt a blended wage index which uses a combination of 1982 and 1984 data. These changes result in a lower wage index value for all areas relative to the national rate; however, the payment rates were adjusted so that the new index would have no effect on total PPS payments.

(4) Issues Affecting Physicians

(a) Physician expenditures under Medicare

Part B supplemental medical insurance (SMI) of the Medicare Program has experienced tremendous growth since its inception, in terms of both services delivered and program expenditures. During Medicare's first full calendar year of operation (1967), total SMI expenditures were $1.3 billion; in 1986, they were $26 billion. Over this 19-year interval, SMI expenditures grew at 17.5 percent per year. SMI accounts for about one-third of total Medicare spending, and physician services make up about 75 percent of SMI expenditures. Although their services comprise less than 25 percent of all Medicare spending, physicians actually may influence more than 70 percent of other medical services used by Medicare beneficiaries.[34]

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[31] Department of Health and Human Services, Health Care Financing Administration, Report to Congress on the Hospital Wage Index as required by Section 2316(a) of Public Law 98-369, Washington, DC, March 28, 1985.

[32] Ibid.

[33] Prospective Payment Assessment Commission, Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1987.

Between 1980 and 1983, Medicare expenditures for physician services increased at an average annual rate (adjusted for inflation) of 12 percent, compared to 6.5 percent for all physician expenditures.[35] In response, Congress froze Medicare fees for participating physicians from 1984 to 1986; the fee freeze was lifted in December 1986 for nonparticipating physicians. The freeze was a qualified success. While the average annual increase in Medicare expenditures for physician services was lower between 1983 and 1986 (9.1 percent) than in previous years, it nonetheless was higher than the annual increase of 7.2 percent for all physician expenditures. This suggests to some policymakers that physicians may be increasing the volume of procedures and visits provided to Medicare beneficiaries to make up for the loss of income that they may have experienced as a result of the fee freeze.

In 1987, HCFA announced that the monthly Part B premium paid by beneficiaries would be increased in 1988 by an unprecendented 38.5 percent—from $17.90 to $24.80. In November 1987, the Senate Special Committee on Aging held a hearing to examine the Part B premium increase. According to testimony from HCFA, growth in expenditures for physicians' services account for nearly 60 percent of the $6.90 increase in the monthly premium. A staff report released at the hearing provides a more detailed discussion of the Part B program and the issues surrounding the premium increase.[36]

OBRA 1987 (Public Law 100-203) contained several provisions to limit physician expenditures under Part B of the Medicare Program. For the 3-month period ending March 31, 1988, prevailing and customary charge levels were maintained at the levels in effect during 1987. A 2.3 percent reduction in Medicare payments to physicians that was initially put into place through the Gramm-Rudman-Hollings sequestration process was extended through March 31, 1988. Effective April 1, 1988, the increase in the medical economic index (MEI) for participating physicians will be 3.6 percent for primary care services (e.g., home and office visits, emergency department services) and 1 percent for other physician services. Nonparticipating physicians will receive an increase of 3.1 percent for primary care services and 0.5 percent for other services. In 1989, the percentage increase in the MEI for participating physicians will be 3 percent for primary care services and 1 percent for other services. The MEI increase for nonparticipating physicians will be 2.5 percent and 0.5 percent, respectively. By January 1, 1989, the prevailing charge differential between participating and nonparticipating physicians will be increased from 4 to 5 percent.

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[34] Physician Payment Review Commission. Medicare Physician Payment: An Agenda for Reform. Washington, U.S. Govt. Print. Office, 1987, p. 13.

[35] Anderson, Gerald F. and Jane E. Erickson. National Medical Care Spending. Health Affairs, v. 6, no. 3, Fall, 1987. p. 101.

[36] U.S. Congress. Senate Special Committee on Aging. Examining the Medicare Part B Program: An Overview of the Issues. Staff Report. 100th Congress, 1st Session, November, 1987.

The Secretary of DHHS will be authorized to monitor the actual charges of each nonparticipating physician for services provided after March 31, 1988. Where a physician knowingly and willfully bills for a service on a repeated basis an actual charge in excess of the maximum allowable actual charge the Secretary will be authorized to apply sanctions.

(b) Inherent reasonableness

Payment for physicians' services is determined on the basis of customary, prevailing, and reasonable (CPR) charges. Under this system, charges for new procedures may be initially priced high because of the new technologies involved. Once a procedure has become established and frequently used, these initial payment levels may be artificially maintained under the CPR system despite technological or productivity advances. For example, improved medical technology resulting in lower costs, or reduction in the time required to perform certain procedures due to increased medical proficiency, should result in lower charges. In the past, this generally has not occurred.

Medicare carriers have the authority to use factors other than CPR in determining whether a charge for a specific service is inherently reasonable. In addition, under COBRA of 1985 the Secretary of DHHS is required to promulgate regulations specifying explicitly the criteria of "inherent reasonableness" that are to be used for determining Medicare payments. In 1986, DHHS focused through regulation on cataract procedures and payments for anesthesiologists who stand by and monitor the general care of a patient during a surgical procedure when the surgeon administers the local anesthesia. Each of these regulations were superceded by OBRA 1986 (Public Law 99-509). Congress specified an approach to inherent reasonableness, specified limits on actual charges when allowable charges are limited through inherent reasonableness, and set inherently reasonable limits on allowable charges and limits on actual charges for cataract surgery and associated anesthesia services. This law reduced by 10 percent the prevailing charges for cataract surgery procedures performed in 1987, and by 2 percent in 1988.

OBRA 1987 specifies that the following 12 physicians' services will be subject to "reasonable charge reductions: Bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatecetomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

The 1987 prevailing charge levels will be reduced initially by 2 percent, and further reductions of up to 15 percent will be implemented pursuant to a sliding fee scale. Prevailing charge levels that are at or above 150 percent of the weighted national average of prevailing charges for the procedure in all localities in the United States for 1987 will be reduced by 15 percent. Where the physician's prevailing charge level for the service does not exceed 85 percent of the weighted national average, there will be no reduction beyond the 2 percent previously mentioned. Where prevailing charge levels are between 85 percent and 150 percent of the weighted national average, the percentage reduction will be based on a straight line sliding fee scale equal to three-thirteenhs of a percentage point for each percent by which the prevailing charge exceeds 85 percent of the weighted national average. In setting the new prevailing charge levels for these services, the Secretary's determination will not be subject to administrative or judicial review.

(c) Other physician payment issues

OBRA 1987 contained several other provisions that affect physicians and physician reimbursement under Medicare. A provision to give incentive payments to physicians providing services in rural and/or medically underserved areas is of particular importance to Medicare beneficiaries experiencing problems with access to health care. An additional payment equal to 5 percent of the allowed amount for services will be made starting January 1, 1989, for service provided in a rural health manpower shortage area, and on January 1, 1991, for services provided in a nonrural health manpower shortage area.

The administration's fiscal year 1988 budget proposal would have modified the fee-for-service reimbursement system for radiology, anesthesiology, and pathology (RAP) services provided for hospital inpatients. Under this proposal, Medicare would have paid an average rate per discharge for all RAP services, similar to DRG's. Congress rejected the administration's plan although certain provisions within OBRA 1987 address these issues. The law reduces payments for anesthesiologists supervising certified registered nurse anesthetists, and requires the Secretary of DHHS to develop a relative value scale (RVS) to serve as the basis of payment for physician radiology and pathology services. The Secretary is to use the RVS and appropriate conversion factors in developing proposed fee schedules. Medicare payments will be based on fee schedules effective January 1, 1989, for radiology services, and by January 1, 1990, for pathology services.

(d) Physician payment reform options

Neither the fee freeze nor the participating physicians program (discussed earlier in the chapter) are considered to be long-term solutions to controlling expenditures in the Part B program. Although the development of the fee schedules discussed earlier for pathologists and radiologists represent an attempt by Congress to get a handle on escalating costs, those services are only a small part of physician expenditures under Medicare. Serious consideration of more fundamental reforms has been hampered by several factors. These include major gaps in the data on what the program is currently paying for, opposition by physician groups to a major alteration in the fee-for-service and voluntary assignment approach, and the uncertainty of the impact of the major reform options on both the program and its beneficiaries. With the increasing need to curb costs and the vast innovation and change occurring in the organization of physician practice, pressures for comprehensive reform nevertheless are likely to mount.

The major alternatives being considered include fee schedules, paying for physicians' inpatient services on the basis of DRG's, or paying for services on a capitation basis. Studies of a number of options currently are being conducted by HCFA and other public and private entities. COBRA 1985 provided for the establishment of an independent Physician Payment Assessment Commission (PPRC) whose mission and on-going duties are to make recommendations regarding Medicare physician payments. PPRC's first report to Congress was released in 1987 and focused primarily on reforms within the present fee-for-service payment system, although future reports likely will concentrate on more long-term reforms. In 1986, the Office of Technology Assessment (OTA) released its study on physician payment options which,[37] along with the work of PPRC and others, has helped form the debate as Congress continues to review possibilities for comprehensive reform. Options under consideration include:

Fee schedules.—The current de facto fee schedules based on local prevailing charging patterns would be replaced by a uniform fee schedule for all physicians services. One method would be to use a relative value scale (RVS), which is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index or weight and other services are assigned higher or lower numbers to indicate their value relative to that service. The use of a RVS could make the payment system more sensitive to a physicians' time, skill, overhead costs, and the complexity of the service. A RVS is not a fee schedule. However, it is translated into a fee schedule by use of a predetermined conversion factor. One drawback to a RVS is that it may be so complex that a workable system would be difficult to develop.

Fee schedules would rationalize the current payment system and place limits on payments for individual services. One key issue is the payment unit. It needs to be designed so that physicians are unable to manipulate the system by unbundling (increasing the number of services provided) or upcoding (coding for a procedure that is reimbursed higher than one actually delivered).

Physician DRG's.—Under the Social Security Act Amendments of 1983, DHHS was required to report to Congress in 1985 on the feasibility of paying for physicians' services provided to hospital inpatients on the basis of DRG's. However, DHHS has not yet given Congress the report.

It is expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined payment for each of the 471 DRG's used under the PPS system. The major advantage of this scheme is that it would establish a specified payment amount for all services provided during an inpatient stay. There are, however, numerous questions about the practicality and appropriateness of a DRG scheme for physicians. The existing DRG coding system is based on resource use in hospitals; it may not be an accurate measure of physicians' input costs. Another question is who is going to receive the payment—the hospital, the attending physician, or the medical staff? One consideration in making this determination is the degree of financial risk imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients requiring more intensive care than the average for a particular DRG. Placing an individual physician at risk could potentially encourage the provision of leass care than was medically appropriate or the avoidance of more severe cases.

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[37] U.S. Congress, Office of Technology Assessment, Payment for Physician Services: Strategies for Medicare, Washington, D.C., U.S. Government Printing Office, February, 1986.

Another issue is the potentially dangerous alignment between hospital and physicians incentives under a DRG payment scheme. Under the existing system, the physician is the last remaining check on quality. If he or she is given the same incentives as the hospital to reduce care, then quality may deteriorate. Other issues involve potential gaming—multiple admissions to maximize reimbursement, shifting care to the outpatient setting, and similar manipulations of the system.

Capitation.—Medicare would contract with an entity, such as a carrier, which would serve as an at-risk insurer in a defined geographical area. Medicare would essentially purchase a specified package of services for a specified per-person price. The entity would be responsible for determining payment amounts and payment units. To assure beneficiary access to care at predictable levels of out-of-pocket costs, an entity would be required to obtain physician participation agreements from a certain percentage of physicians in the geographic area. The Federal Government would be required to determine the per-person payment. The system could be designed to be mandatory for all beneficiaries or optional.

The administration, while supporting capitation as a long-term solution, has four short-term approaches they believe would help control Part B costs under the present fee-for-service system. These approaches include limiting payment fees on certain overpriced procedures, and intensive claims review to validate medical necessity and appropriateness of the level of care. The administration also supports bundling payments (providing one or a small number of payments for a particular diagnosis) to increase incentives to provide only medically necessary and appropriate services. Finally, the administration would encourage Medicare beneficiaries to use preferred provider networks. Providers participating in the networks would be those identified by HCFA as providing high quality care at affordable prices. Intensive utilization review and financial incentives would be used to encourage more appropriate volume and level of intensity of services by providers participating in the networks.

There are many questions about the effects of these proposals and they are likely to be heavily scrutinized by Congress and organizations representing the elderly. Initial concerns regarding the preferred provider networks and the capitation plan include whether beneficiaries will have the information and knowledge to make rational selections among the various plans. There is also a question of skimming and adverse risk. For example, the healthier beneficiaires may opt for the capitated scheme leaving the basic Medicar Program to absorb the high cost, heavy care patients. Finally, there is a concern that the administration will be driven by budget concerns to hold the capitation payments low and to pare down the required benefit package.

While several of the provisions in OBRA 1987 that address the issue of physician payment reform are somewhat short-term or limited in nature, it nonetheless represents a movement toward more fundamental change. Because the need for reform is an issue that Congress and the current administration basically agree upon, finding and implementing solutions likely will occur more readily than if it were a politically contentious problem. Since 1988 is an election year, however, it is unlikely that sweeping reforms will take place.

(5) Issues Affecting Medicare Health Maintenance Organizations

The participation of health maintenance organizations (HMO's) in the Medicare Program represents yet another attempt by the Federal Government to stem rising health care costs. Like all health cost containment strategies, the challenge facing the Medicare HMO program is to achieve this objective without compromising health care quality. In 1987, Congress continued to grapple with a number of issues related to these dual, but potentially conflicting, goals. In the course of the year, congressional action was taken to address problems related to post-contract protection of Medicare beneficiaries against non-Medicare covered health costs, quality of care, and HMO capitation rates.

(a) Post-contract protection

An attractive feature of many HMO's is the availability of health care coverage which is more generous than that provided under the combination of Medicare and most supplemental, or medigap, insurance policies. Accordingly, many beneficiaries join HMO's as an alternative to traditional medigap policies. However, if an HMO closes or ceases participation in the Medicare Program, a beneficiary may be left facing unanticipated, uncovered health costs. This is particularly the case for the beneficiary who cannot find an alternative medigap policy for the HMO coverage that does not exclude, as most such policies do, existing medical conditions for a period of several months. As a result, a participant of an HMO which has closed may be left totally vulnerable to non-Medicare covered health care costs.

In 1987, two events highlighted this potential problem. First, the Florida-based International Medical Corporation, Inc., (IMC), one of the Nation's largest HMO's with about 150,000 Medicare beneficiaries, declared bankruptcy. Second, 29 Medicare HMO's—18 percent of the total—pulled out of the medicare HMO program.

In the case of IMC, another health care corporation assumed responsibility for providing roughly similar services to the IMC enrollees. This arrangement prevented Medicare enrollees from suffering any adverse financial consequences arising from lack of supplemental health insurance. With respect to the HMO withdrawals from the Medicare Program, few beneficiaries were involved due to the small size of the contracts in question.

Nevertheless, both of these events drove home the point that Medicare enrollees in an HMO are at some risk of sudden supplemental health care costs. To guard against this, Congress included provisions in the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) requiring HMO's to ensure that Medicare enrollees are provided with supplemental coverage in the event the HMO ceases to serve such beneficiaries. Additional provisions required HMO's to inform Medicare enrollees of the possibility that its Medicare contract may be cancelled at some future time.

(b) Quality of care

Following a year-long Senate Special Committee on Aging investigation, Senator Heinz released a report in 1987 on HMO's with Medicare risk contracts that found cases of questionable marketing and biased enrollment practices, involuntary disenrollments, and inadequate medical care in a number of HMO's. While the findings were preliminary and not intended to be representative of the industry as a whole, the report concluded that HCFA was not fulfilling its monitoring responsibilities.

To address these problems, the report recommended that: (1) Congress enact stricter standards regarding the promotion, advertising, and sale of Medicare HMO plans, as well as penalties for violations of such standards, (2) HCFA and Medicare HMO's jointly promote improved beneficiary understanding of the limitations of HMO membership, (3) beneficiaries receive protection in cases of contract terminations, and (4) HMO reviews include a greater emphasis on quality of health care services.

Groups representing the HMO industry criticized the report for focusing only on grievances within a limited number of HMO's, thereby unfairly and inaccurately magnifying the problems within the Medicare HMO program. They further expressed their conviction that the report should not be taken as an accurate portrayal of the entire industry.

To prevent wrongful practices among HMO's, Congress included provisions in OBRA 1987 to broaden and increase monetary sanctions against HMO's which selectively deny enrollment to a Medicare beneficiary or health care to a Medicare enrollee. A penalty of up to $100,000 was established for engaging in biased enrollment, and existing fines were increased from $10,000 to $25,000 for denying a beneficiary medically necessary services. Similar sanctions were set for charging premiums in excess of the legal amount, involuntarily disenrolling, or refusing to re-enroll a beneficiary on the basis of health status.

The 1987 reconciliation legislation also delayed by 1 year the effective date of the prohibition against so-called incentive payments. HMO management often provides such payments to physicians as a way to reduce utilization. Out of concern that the unrestricted use of incentive payments could reduce access to health care, Congress originally had barred such practices beginning in April 1989, and mandated a DHHS report on acceptable incentive payment systems. The extension to April 1990 was needed to provide time to fully consider any recommendations in the DHHS report, which is not expected to be available until mid 1988.

(c) HMO-capitation rates

A continuing controversy in the Medicare HMO program surrounds the capitation rates used to determine the prospective payments a risk-contract HMO receives. The formula for such rates, referred to as the average adjusted per capita cost (AAPCC), accounts for a number of variables, including beneficiary age and sex and the location of the HMO. Rates can vary dramatically, and HMO's can receive widely differing payments. This and other related problems have led many to criticize the AAPCC.

To develop a better payment system, Congress included provisions in OBRA 1987 which authorized the Secretary of DHHS to establish demonstration projects to test alternative rate-setting methods. The General Accounting Office also was called upon to study the AAPCC and any preferred alternatives.

OBRA 1987 also authorized the Secretary of DHHS to enter into a limited number of contracts with employers and unions to provide Medicare benefits to retirees. This authority carries with it a limitation on the amount of profit the project's sponsor may retain and a number of requirements designed to protect the rights of beneficiaries.

In light of the urgent need to hold down Medicare costs, the Medicare HMO program holds the promise of providing cost-effective, quality health care. As in 1987, Congress can be expected to continue to adjust the program to assure that cost-effectiveness is not achieved at the expense of Medicare beneficiaries.

3. PROGNOSIS

In 1987, the Medicare Program was the recipient of fiscal year 1988 budget cuts amounting to $2.1 billion. In early 1988, in an effort to streamline the budget process and in order to adjourn early enough for sufficient time to be available for election year campaigning, the leadership of the Congress reiterated their commitment to following the guidelines of the 1987 budget summit for the fiscal year 1989 budget. Should the administration submit a fiscal year 1989 budget proposal that is perceived as being relatively consistent with the budget summit agreement, 1988 could be a year of unsurpassed cooperation between the two branches of Government in their continuing effort to reduce the Federal deficit. Should this occur, however, the Medicare Program will be targeted for a $3.8 billion cut in its fiscal year 1989 budget.

If acceptable budget legislation emerges, Medicare cuts largely will be shouldered by health care providers. On the heels of an unprecedented Part B premium increase and the expected implementation of a new catastrophic health care premium, the Congress will hesitate to pass along a significant proportion of Medicare cuts to beneficiaries.

As a result of the 38.5 percent increase in the 1988 Part B premium, the Congress and aging advocates will be closely monitoring expenditures out of the Supplemental Medical Insurance (SMI) Trust Fund. Should Medicare Part B expenditures for physician services continue to skyrocket, pressure for physician reimbursement reform will proportionately increase. Although it appears unlikely that comprehensive reform in this area be enacted by the

100th Congress, there may well be overwhelming pressures for implementation of temporary stop-gap measures, such as reducing beneficiary liability for Part B program costs. In addition, selected physician services and specialties likely will be targeted for further reductions in reimbursement.

Hospitals may receive more favorable treatment than physicians. In early 1988, studies released by both the DHHS' Inspector General's office and the Prospective Payment Assessment Commission (ProPAC) reported that hospital profits on Medicare inpatients had dropped. The DHHS study, largely corroborated by the ProPAC study, found that: (1) hospital profits on Medicare inpatients dropped from about 14 percent of revenue in 1984 and 1985 to 9.6 percent in 1986, (2) one-third of all hospitals operated at a net loss on Medicare, and (3) rural hospitals as a group suffered a net loss. Further, preliminary esimates by the ProPAC study determined that fiscal year 1987 hospital profits were 2 percent. The reports concluded that reduction in profits were largely attributable to rising hospital costs which are outstripping inflation, declining admissions, and the fact that the Federal government has slowed the amount of annual increases in the hospital reimbursement rate. Hospitals can be expected to use these findings to bolster their agument that they should not be targeted for further Medicare cuts.

With the findings of the DHHS and ProPAC study in hand, some Members of Congress, concerned that reduced reimbursement may threaten access to and quality of health care, will hesitate from supporting significant hospital reimbursement reductions. In contrast, Congressman Pete Stark, Chairman of the House Ways and Means Subcommittee on Health, can be expected to maintain his past position that hospital managers should not be rewarded for failing to control rising hospital costs.

As Congress and the administration continues to look for ways to reduce the Federal deficit, hospitals (as the largest recipient of Medicare payments) will continue to receive close scrutiny during budget negotiations. To strike a compromise on the varying reimbursement approaches being discussed, Congress can be expected to continue to give favorable treatment to financially vulnerable hospitals, such as those in rural settings. However, Congress will continue to try to find as much savings as possible from hospitals which are perceived to be faring very well under the prospective payment system.

If an agreement on a budget cannot be achieved, much more severe cuts from the Gramm-Rudman-Hollings budget sequester mechanisms would take place. Although Medicare is shielded from the full force of Gramm-Rudman-Hollings, it nevertheless would be a recipient of major cuts if a sequester was ordered. Whichever budget reduction process is pursued, however, Medicare and its over 31 million beneficiaries will be directly or indirectly affected by the process of belt-tightening and program retrenchment.

Beyond completing the long process of formulating a Federal budget, the first order of health policy business for the Congress in 1988 will be to complete the joint Senate-House conference on the catastrophic health care legislation. As previously noted, the prescription drug provision and the financing approach will be hotly debated in conference. However, the catastophic health bill still has a great deal of momentum behind it and it is expected that a compromise will emerge, pass the Congress, and be signed into law.

Following passage, implementation of the catastrophic health care legislation's new provisions will ensue. As of this writing, it appears most likely that as a result of administrative complexities, the new benefits will not be in place until January 1989. However, prior to and during implementation, a public awareness campaign by the Department of Health and Human Services and several congressional committees regarding what the revamped Medicare Program will and will not cover is expected to take place.

The shortcomings of the catastrophic health care legislation will likely be highlighted during the second session of the 100th Congress. The lack of protection against long-term care expenses (detailed in the next chapter), the adequacy of the prescription drug benefit, and the issue of ever-increasing out-of-pocket costs for physician services can be expected to be a major focus of the aging and health policy debate.

Beyond addressing the shortcomings of the current Medicare program, another continuing challenge will be to monitor the quality of care that Medicare beneficiaries are receiving. One way to begin to accomplish this is to compare hospital mortality rates. In late 1987, the Health Care Financing Administration publicly-released mortality data on 6,000 acute care hospitals. Of the 6,000 hospitals, 180 hospitals (3 percent) fell below predicted mortality range. Although all interested parties agreed that the information contained in the seven volume list could not be used as an accurate measure of overall hospital quality, many concluded that the information can be used as a tool from which more questions can be asked. HCFA plans to make further refinements on this data and will release this publication on an annual basis. Similar information on physicians also may be released in the future. As the measures improve, important strides toward making the health care consumer a more informed consumer will be achieved.

In an environment in which deficit reduction continues to take priority on the national policy agenda, the Medicare Program faces difficult times ahead. With budget cuts slowing down reimbursement rates for providers, pressures will increase to deliver care at the lowest cost possible. Continued careful and constant monitoring will be required to make certain that providers do not sacrifice quality care in order to reduce their costs.

The success of the health care cost containment reforms rides on the willingness of patients, providers, and regulators to get the most out of an increasingly lean system. Similarly, the success of new approaches to deal with health care needs of the Nation depends on the ability of policymakers and advocates to develop initiatives that can either significantly alter budget priorities or offer creative, cost-effective health policy alternatives.

B. HEALTH BENEFITS FOR RETIREES OF PRIVATE SECTOR EMPLOYERS

1. OVERVIEW

Since the enactment of Medicare in the mid-1960's the prevalence of employer-sponsored retiree health benefit packages has increased dramatically. Once Medicare had been passed, employers could offer health benefits to their retirees with the knowledge that the Federal Government would pay for many of the medical costs incurred by company retirees 65 and older.

The role of employers in providing retiree health benefits has gained increasing recognition in recent years. While a relatively small percentage of retirees currently are covered by employer plans, those who receive health care benefits depend heavily upon them. The increasing awareness of the importance of health benefits to retirees however, has resulted in growing concern about the lack of benefit security. At the same time, growing costs for employers and the looming threat of tremendous unfunded long-term health plan liabilities have raised employer anxieties about the future viability of retiree health benefits.

2. BACKGROUND

Many employers and unions sponsor group health insurance plans which provide coverage for retirees not yet eligible for Medicare, and supplement Medicare benefits for retirees 65 and older. Medicare, which covers more than 32 million Americans, is the fundamental health benefit for almost every American over 65. However, Medicare neither meets all of the needs of retirees over 65 nor covers retirees under age 65 unless they have qualified for Medicare as a result of a disability or end stage renal disease. Thus, employer and union sponsored retiree health plans provide an extremely important form of insurance protection for older Americans.

While a large number of employees presently are not protected by employer sponsored plans, retiree health coverage is included in the benefit packages offered by many employers. According to the Employee Benefit Research Institute (EBRI), 76 percent of full-time health plan participants in 1986 had coverage continued after early retirement. Of those, 90 percent received continued coverage after age 65. However, a 1986 Department of Labor (DOL) report estimated that in 1983, only one out of every six Americans 65 or older was receiving a portion of his or her health coverage from an employer or union. DOL estimated that approximately 6.9 million retirees were covered by private employer or union sponsored health plans, with 4.3 million of these retirees (16 percent) 65 or older and 2.6 million under 65. According to a 1987 article by Jonathan Dopkeen in *Health Services Research*, approximately 25 million active workers (34 percent of the national work force) work for employers sponsoring retiree health benefit plans.

For those who have employer-provided coverage, however, the benefit is important. A major benefit is simply the opportunity to continue participating in the employer's group after retirement rather than being forced to purchase an individual health insurance policy. The cost of purchasing an individual policy before age 65 frequently is prohibitive, and retirees may have difficulty finding an insurance company willing to offer them coverage if they have a pre-existing medical condition. Through lower administrative costs and high employer contributions, group insurance typically offers beneficiaries a higher range of benefits at a lower cost than persons with individual policies can obtain.

Retirement medical benefits are most often provided by large employers. According to survey data collected by the Washington Business Group on Health, approximately 8 out of 10 large employers provide post-retirement health coverage. Indeed, a number of surveys have shown that the availability of retiree health coverage increases with the size of an employer. In 1987, using data from several of these surveys. Dopkeen found that 42 percent of employers with 50 to 99 employees provide health benefits and 46 percent of employers with 100 to 149 employees have plans. These figures increase steadily with the size of the employer to 62 percent for firms with 500 to 999 employees, 77 percent for those employing 1,000 to 4,999 persons, 89 percent for firms with 5,000 to 9,999 employees and 94 percent for firms employing more than 10,000 workers.

Those employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. At that point, most corporations provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare. One of three approaches may be used: A "carve-out," a "Medicare supplement," or a "coordination of benefits."

The most common is the carve-out plan. These plans provide for continued retiree coverage under a group plan, but do not cover services for which Medicare pays, thus avoiding duplicate coverage. Carve-out plans tend to be the least costly because retirees share their costs through copayments and deductibles.

Under the coordination of benefits approach, a plan pays what it would in the absence of Medicare, but the total payment is limited to 100 percent of the cost actually incurred. Because this type of plan pays for services not covered by Medicare, its costs are affected by changes in Medicare benefits.

The Medicare supplement avoids this problem by specifying exactly the benefits that will be paid by the plan. In addition, the supplement can tailor benefits to the needs of the retiree. While the costs of the supplement can be more easily controlled, this approach requires the design and administration of a separate plan. It also may result in a change in benefits when early retirees reach age 65.

3. Issues

(A) PROTECTION FOR RETIREES

Traditionally, employers have not pre-funded health benefits, preferring instead to handle these obligations on a pay-as-you-go basis. In fact, many employers still do not understand the funding implications of their benefit plans. This lack of awareness has resulted in estimates that current unfunded liabilities for employee health benefits range anywhere from $85 billion (according to EBRI) to $2 trillion (according to a 1986 report released by the House Select Committee on Aging).

A sharp increase in congressional awareness of the vulnerability of retiree health benefits occurred in 1986 when LTV Corp. filed for reorganization under Chapter 11 of the U.S. Bankruptcy Code. LTV's immediate attempt to terminate the health and life insurance benefits of more than 78,000 of its retirees sparked both congressional and public concern about the protection of many retirees' health benefits if their former employers should declare bankruptcy or suddenly choose to terminate their health plans. As Congress rushed to secure these benefits for LTV's retirees, it came face-to-face with the difficult reality of this large unsecured and unfunded promise to current and future retirees.

The actions of LTV illuminated the problems surrounding the tremendous unsecured promise of health benefits that has been made to retirees across the country. While LTV, in response to a retaliatory strike by the Steelworkers and legislative activity by the Congress, obtained permission from the bankruptcy court to reinstate health benefits for 6 months, it was evident that serious corrective measures were necessary. Therefore, Congress began work on a series of bills to protect LTV's retirees as well as others in similar situations.

Four major laws were enacted containing retiree health benefit provisions, including:

(1) A provision in the Tax Reform Act of 1986 (Public Law 99-514) permitting the LTV Corp. to use certain tax credits to fund the purchase of health and life insurance benefits. The intent of this provision is to ensure that the bankruptcy court will permit the use of any income resulting from these tax credits to pay for the health and life benefits of LTV retirees;

(2) A provision in the Consolidated Omnibus Budget Reconciliation Act (COBRA) requiring the 18-month continuation of the provision of health benefits to retirees who otherwise would lose their health coverage upon retirement;

(3) A provision in the Omnibus Budget Reconciliation Act of 1986 (OBRA) (Public Law 99-509) which amended COBRA to require that companies entering chapter 11 bankruptcy after July 1, 1986, continue health coverage for their retiring or retired employees for life, as well as continue coverage for the spouses and dependent children for 3 additional years in the event of their death; and

(4) A provision in the continuing appropriations resolution for fiscal year 1986 (Public Law 99-591) requiring that the health and life benefits being paid by companies in chapter 11 bankruptcy as of October 2, 1986, continue to be paid until May 15, 1987, thus precluding LTV and other companies entering bankruptcy from terminating retiree benefits until Congress could enact more substantive legislation. This provision was twice extended [Public Law 100-41 and Public Law 100-99], but expired October 15, 1987.

On August 7, 1986, the Senate Special Committee on Aging held a hearing into the difficulty of securing health benefits for retirees whose employers enter bankruptcy. Witnesses testified that while

Congress could require vesting of health benefits at retirement, vesting would discourage employers from providing these benefits for current workers thus resulting in a reduction of retiree health benefit coverage. In addition, while vesting would protect the health benefits of retirees of existing companies, it would not adequately protect the retirees of bankrupt companies. Retirees would still lose their coverage and have only an unsecured claim for the value of the benefits. The committee heard testimony that, to survive bankruptcy, retiree health benefits would have to be funded and guaranteed in much the same way pension benefits are today. However, given the present economic environemnt, it is unlikely that even the most aggressive efforts would result in the adequate funding of retiree health benefits in the near future.

Retirees are finding some measure of protection in the Federal courts for their promised health benefits, and employers increasingly are being forced to recognize what had been, until recently, an informal obligation as a real legal and financial liability. In *Eardman* v. *Bethlehem Steel Corp.* [607 F. Supp. 196 (1984)], 16,000 nonunion retirees objected to changes in their medical plans which were instituted by Bethlehem Steel to contain costs. A U.S. district court, reviewing the terms of these plans, held that where the employer did not clearly retain the right to reduce or cancel retiree benefits, these benefits could not be reduced. After filing an appeal, Bethlehem agreed to provide a permanent health program for the retirees by combining features of the original and modified medical plan.

A Tennessee case, *Musto* v. *American General Corp.* [615 F. Supp. 1483 (1985)], went even further. While *Bethlehem Steel* had implied that employers were free to modify retiree benefits if those retirees had been informed of the possibility prior to leaving their job, *Musto* prohibits modification by the employer regardless of what employees or retirees have been told. *Musto* holds that employer health benefits "vest" upon retirement and are unchangeable thereafter regardless of the reservation clauses employers may have incorporated into plan documents.

While some hail the *Musto* decision as a far-reaching development in the protection of retirees' rights, others question whether its line of reasoning will do more harm than good. The Washington Business Group on Health (WBGH) has raised the concern that a prohibition against any change in retiree health plans would prevent employers from adopting plan modifications designed to contain escalating health care costs and increase the quality of care provided. The WBGH has warned that depriving employers of the ability to modify plans in any way will have the effect of "locking in" plans which are outmoded and wasteful, and will impose the entire burden of cost containment on future retirees.

The lower court decision in *Musto* has been overshadowed by the 6th U.S. Circuit Court of Appeals decision in another case: *Hansen* v. *White Farm Equipment Co.*[1] In this case, the company cancelled retiree medical coverage when it filed for chapter 11 reorganization. A U.S. district court reversed a bankruptcy court decision and held that the company had to continue coverage because retirees had a vested right to their health benefits at retirement and the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear.[2] On appeal, the appeals court reversed the district court, ruling that although retirees do have contractual rights in post-employment benefits, they are not "automatically" vested upon retirement, but are subject to the terms of the contract.[3] The court held that only Congress, not the Federal courts, has the power to declare retiree medical benefits vested. The case was remanded to the bankruptcy court for a determination as to whether the information conveyed to the retirees clearly and expressly reserved the right of the company to terminate benefits.

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[1] 23 Bankruptcy Reporter 85 (1982).

The 6th circuit decision in *White Farm* directly contradicts the *Musto* ruling by a lower court in the same circuit on vested benefits under Federal common law.

(B) FUNDING OF RETIREE BENEFIT PLANS

As employers face increasing pressure to guarantee the health benefits they have promised their retirees, employers are becoming more worried that they are not financially prepared to bear these burdens and that they may need to consider some kind of pre-funding mechanism. This realization is occurring because of several factors: First, the growing cost of medical care has led employers to recognize the vast amount of resources that will be needed to provide health benefits to retirees in the future. This is particularly true for employers involved in older industries which have a high ratio of retirees to active employees.

Employers also are afraid that the Federal Government, in its efforts to contain costs under Medicare, will make changes in Medicare that will shift greater responsibility for paying for health care. The unpredictability of future Medicare policy is of particular concern in light of the various court rulings that have held employees liable for the delivery of health benefits they have promised.

A third factor pressuring employers is the growing recognition that these are current liabilities of an employer which affect its net worth. In 1984, the Financial Accounting Standards Board (FASB) adopted an interim rule requiring that employers include—at least in a footnote on their annual balance sheet—a statement about how, or whether, they prefund their health benefit plans. The Board currently is developing more comprehensive accounting rules, a draft of which is expected to be released for public comment in 1988. The new rules will require corporations to report both their accrued and current expenses for retiree health benefits. This will focus attention on the adequacy of employer funding of such benefits.

FASB's new reporting requirements may significantly effect employers with large unfunded liabilities. Until now, financial markets generally have not considered the current and future health benefit liabilities of companies to their retirees when investing.

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[2] 42 Bankruptcy Reporter 1005 (1984).

[3] *Hansen* v. *White Motor,* 788 F.2d 1186 (6th Cir. 1986).

Now that companies will be forced to reveal these liabilities, however, many face the possibility of having their value reassessed by financial markets. This could be especially true for companies already experiencing financial difficulties.

These three factors have led some employers to reconsider the desirability of pre-funding retiree health benefit plans. Relatively few employers now pre-fund these benefits and, to date, no consensus exists as to whether pre-funding is desirable. Some employers feel that their obligation to provide these benefits is now legally unavoidable and, therefore, it is wise to pre-fund. Others have not yet accepted the inevitability of these obligations and continue to object to pre-funding.

Pre-funding will remain undesirable until tax incentives are available offering favorable treatment to employers for funds set aside to pay for future health benefits—similar to the favorable tax treatment that pension contributions receive. Yet, before the Federal Government will provide favorable tax treatment for these amounts, it must feel that some guarantees exist that these amounts will be used exclusively for retiree health benefits—in other words, that a clear liability exists necessitating pre-funding and the deferred taxation this entails.

Without some minimum standards guaranteeing that certain categories of retirees would be eligible for certain minimum benefits, determinable in real actuarial fashion, the Government has been unwilling to provide a tax mechanism for funding these benefits. In fact, as of January 1, 1986, one mechanism for pre-funding has been removed from the tax code. Prior to the passage of the Deficit Reduction Amendments of 1984 (DEFRA), employers were able to establish VEBA's, or "voluntary employee benefit associations," into which they could set aside unlimited funds to provide for retiree health benefits. To receive a tax deduction for these funds, the employer only had to certify that the funds would be used to pay for benefits.

The Treasury Department viewed these rules as inviting abuse. Treasury believed that although the VEBA mechanism was not widely used, unlimited deductions were not apprpriate for "contributions" which faced neither reporting and disclosure requirements, nor limitations on total funding.

DEFRA placed the burden on employers to justify the need for a tax-favored funding mechanism for retiree health benefits. The act placed a cap on the amount that could be set aside for tax purposes, thus decreasing the value of VEBA's as prefunding mechanisms. Employers now are limited to setting aside no more than the total of their current expenditures for a particular benefit, plus 75 percent of that amount to account for future uncertainties. This 75 percent limit, according to benefit consultants, is far below the amounts needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care.

4. LEGISLATION

Legislation was enacted in 1987 largely in response to LTV's 1986 attempt to terminate its retiree health plan. Two bills were stop-gap measures aimed at requiring the continuation of health insurance for LTV's retirees and two others proposed a more permanent solution to the problem.

Two bills introduced by Senator Howard Metzenbaum to temporarily protect retiree health benefits from termination were signed into law during 1987. Both provided for extensions of the authority of a bankruptcy trustee to provide health benefits to retired former employees under a plan, fund, or program maintained or established by the debtor. The first bill, S. 903, extended the authority from May 15, 1987 to September 15, 1987 (Public Law 100-41), and the second, S. 1577, extended the authority to October 15, 1987 (Public Law 100-99).

Although two more substantive bills were passed during 1987, both await further action by a conference committee. The Retiree Benefits Security Act (S. 548), introduced by Senator Metzenbaum, amends title 11 of the U.S. Bankruptcy Code to provide explicit procedures for the handling of health and life insurance benefit claims of union and nonunion retirees in a reorganization. S. 548, which passed the Senate on July 24, 1987, requires companies to pay all retiree benefits without modification unless either the court orders payment modification or the retirees' authorized representative agrees to modifications. The bill also requires that payments for retiree health benefits be treated as an administrative expense, thus giving them first priority for payment under the Bankruptcy Code.

The second substantive piece of legislation, H.R. 2969, was introduced by Representative Peter Rodino. This bill, which passed the House of Representatives on October 13, 1987, was similar to S. 548. However, many congressional Representatives from districts containing LTV retirees, as well as the retirees themselves, argue that the bill is inadequate. They believe that the Rodino bill deals more strongly with future situations and fails to adequately address present-day problems. As the result of a recent collective bargaining agreement ensuring the continuation of health benefits, LTV retirees receiving a pension of more than $200 per month now are required to pay a monthly insurance premium of $26.82. Representatives of the retirees believe that should the Metzenbaum bill become law, the chances of a bankruptcy judge ordering the elimination of the extra charge will be excellent. If the provisions of H.R. 2969 become law, however, the retirees believe that eliminating the extra charge will be next to impossible.

5. PROGNOSIS

While serious legislative reform to secure or fully fund retiree health benefits seems unlikely in the near future, the legislation passed during 1987 to protect retiree health benefits in bankruptcy provides an important starting point. If signed into law, this legislation will prevent companies from unilaterally terminating retiree health and life benefits upon filing for bankruptcy and will require that firms negotiate a reasonable alternative plan with their employees, if necessary.

The anticipated FASB ruling—requiring employers to list their retiree health benefit obligations as a financial liability—should force a dramatic alteration in employers' treatment of retiree health benefit plans. In addition, a long overdue Treasury study should produce valuable information about options for funding retiree health benefits.

Whatever issues may be debated during 1988, in the long-term, significant alterations in how employers fund their health plans likely will take place. Many employers also may alter significantly the types of benefits they offer their employees. Since it will be difficult to formulate a package acceptable to employers, employees, and retirees, however, broad reforms are improbable in the near future.

C. HEALTH RESEARCH AND TRAINING

1. Background

Biomedical research is one of the most fundamental, yet often overlooked, ways to reduce health care costs and the need for long term care. The Federal Government's substantial investment in biomedical research for nearly four decades has resulted in America's outstanding advances in science and health. However, the Federal Government's investment in medical research is only about 1.2 percent of total spending on health care in the United States, which was $456.4 billion, or 10.8 percent of the gross national product, for 1985. In addition, the administration has proposed budgets which would significantly reduce Federal support for biomedical research as well as decrease the number of funded research grants.

Although the National Institutes of Health (NIH), is the major biomedical research arm of the Federal Government, the Alcohol, Drug Abuse, and Mental Health Administration, particularly the National Institute of Mental Health (NIMH), also is involved in considerable research activity relating to the elderly.

With the rapid expansion of the Nation's elderly population, the incidence of diseases, disorders, and conditions afflicting the aged also is expected to increase dramatically. For example, the incidence of Alzheimer's disease and related dementias is projected to double before the end of the century and quadruple by 2040, if biomedical researchers haven't identified the cause and developed effective treatments.

In many parts of the United States, the health care system is unable to deal with the current needs of elderly patients suffering from dementia and other diseases. To meet those needs, the Federal Government is expanding the scope of its research activity regarding services needed by these impaired elderly and their families. Specialized professional training for health care providers working with geriatric patients is another emerging, significant, and basically unmet need that Congress is beginning to address.

(A) THE NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH), which celebrated its centennial in 1987, seeks to improve the health of Americans by increasing understanding of the processes underlying disease, disability and health and by helping to prevent, detect, diagnose, and treat disease. It supports behavioral and biomedical research through grants to facilities, conducts research in its own laboratories and clinics, and trains young scientific researchers.

With the rapid aging of the U.S. population, one of the most important research goals is to distinguish between aging and disease in older people. Findings from NIH's extensive research into both of these areas increasingly challenges health providers to seek causes, treatment, and prevention of the many ailments of the elderly, rather than to dismiss them as being the effects of natural course of aging. A more complete understanding of normal aging as well of disorders and diseases also facilitates progress in health promotion, medical education, and health policy and planning.

(1) History of NIH

NIH traces its beginning as a health research organization of the Federal Government to the establishment of the Laboratory of Hygiene for research on cholera and other infectious diseases in 1887 as part of the Marine Hospital Service at Staten Island, NY. The Marine Hospital Service was a forerunner of the present Public Health Service. In 1930, Congress passed the Ransdell Act, which renamed the Laboratory of Hygiene and created the National Institute of Health. The Ransdell Act also authorized a system of fellowships and the construction of two buildings, "for study, investigation, and research into the fundamental problems of the diseases of man."

With the passage of the Social Security Act in 1935, up to $2 million annually was authorized for the "investigation of disease and problems of sanitation," but appropriations ranged from $375,000 in fiscal year 1936 to $707,000 in fiscal year 1940. Congress authorized the creation of the National Cancer Institute in 1937 as a division of the Public Health Service. The Public Health Service was revised and consolidated in 1944, giving NIH its postwar legislative basis establishing permanent, general authority to conduct research.

The National Heart Act, passed in 1948, established the National Heart Institute and changed the name of the National Institute of Health to the National Institutes of Health. Since then, many more institutes have been established and the NIH budget has grown from $8 million to almost $6.7 billion.

(2) Health Research Extension Acts of 1983 and 1985

These bills, to amend the Public Health Service Act relating to the National Institutes of Health, became a point of confrontation between the White House and the Congress. The Health Research Extension Act of 1983 was passed by Congress and then pocket vetoed by the President in 1984 after Congress adjourned. It was reintroduced in 1985, again passed by Congress, and, once again, was vetoed by the President. This time, however, the veto was overridden by a 380–32 in the House and 89–7 in the Senate.

The administration's objections focused on the creation of a new nursing research center, the imposition of a uniform set of authorities on all research institutes, and additional administrative and program requirements. However, in 1985, the President, in his veto message, acknowledged the need to establish a National Institute of Arthritis, a point on which he had vetoed the Health Research Extension Act in 1984.

The new legislation also reauthorized the National Cancer Institute and the National Heart, Lung, and Blood Institutes, established a Biomedical Ethics Advisory Board, increased emphasis on the humane care of laboratory animals, and provided explicit statutory authority for each of the institutes while retaining the authority of the Secretary of the Department of Health and Human Services to support research and reorganize the institutes.

In addition, the Health Research Extension Act of 1985 called for the Secretary of Health and Human Services to conduct a study of the adequacy and availability of personnel needed to serve the health needs of older Americans, including home and community-based care, through the year 2020. The study report also was to make recommendations concerning the number and training needs for primary care physicians and other personnel required, and necessary changes needed to finance such training.

(3) The Institutes

Much of the research into particular diseases, disorders and conditions at NIH is collaborative, with different institutes investigating pathological aspects related to their specialized approach. At least 10 of the NIH research institutes investigate areas of particular importance to the elderly. They are:

National Institute on Aging,
National Cancer Institute,
National Heart, Lung, and Blood Institute,
National Institute of Dental Research,
National Institute of Diabetes and Digestive and Kidney Disease,
National Institute of Neurological and Communicative Disorders and Stroke,
National Institute of Allergy and Infectious Diseases,
National Eye Institute,
National Institute of Arthritis and Musculoskeletal and Skin Diseases, and
National Center for Nursing Research

(a) National Institute on Aging

The National Institute on Aging (NIA) was established in 1974 in recognition of the many gaps in scientific knowledge of aging processes. NIA conducts and supports a multidisciplinary program of geriatric research, including the biological, social, behavioral, and epidemiological aspects of aging phenomena. Through research and health information dissemination activities, its goal is to prevent, alleviate, or eliminate the physical, psychological, and social problems faced by many older people.

NIA areas of biomedical and clinical research include Alzheimer's disease, molecular genetics to understand the basic mechanisms of aging, the ability of transplanted brain cells to enhance memory and reverse learning deficits in animals, brain metabolism and function as related to dementia and aging, and osteoporosis, hip fractures and falls.

(b) National Cancer Institute

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. Of all new cancer cases reported, more than half are elderly patients, and more than 60 percent of all persons who die of cancer each year are older Americans.

Although the rate of cancer survival has increased to 50 percent from the 30 percent of the 1950's due to advancements in surgery, radiation, and chemotherapy treatment, the rate of overall cancer incidence and mortality has been increasing, particularly in those 55 and older.

In addition to basic and clinical, diagnostic, and treatment research, NCI supports a prevention and control program emphasizing such programs as assistance to stop smoking.

(c) National Heart, Lung, and Blood Institute

The National Heart, Lung, and Blood Institute (NHL&BI) focuses on diseases of the heart, blood vessels, blood, and lungs and on the management of blood resources. Three of the most prevalent chronic conditions affecting the elderly—hypertension, heart conditions, and arteriosclerosis—are studied by NHL&BI. In 1985, more than 1 million deaths were reported from all of the diseases under the purview of the Institute with associated health care costs exceeding $143 billion. Nearly 40 percent of all elderly suffer from hypertension, 25 percent from a chronic heart condition, and 8 percent from arteriosclerosis.

Current research efforts include cholesterol-lowering drugs, DNA technology, and genetic engineering techniques for treatment of emphysema, basic molecular biology research in cardiovascular, pulmonary, and related hematologic research, and regression of arteriosclerosis.

The institute also conducts an extensive professional and public education program on health promotion and disease prevention, particularly as related to blood pressure, blood cholesterol, and coronary heart disease. This has played a signfiicant role in the 52 percent decline in stroke death and 40 percent decline in heart disease over the past 20 years.

(d) National Institute of Dental Research

The National Institute of Dental Research (NIDR) supports and conducts research and research training on oral health and disease. Major goals of NIDR include prevention of tooth loss and preservation of the oral tissues from the main dental diseases, caries and periodontal. Other research areas include birth defects affecting the face, teeth, and bones; oral cancer; infectious diseases; chronic pain; epidemiology; and basic studies of oral tissue development, repair, and regeneration.

In a national study in 1986–87, NIDR found that 42 percent of men and women age 65 and older examined in the survey had lost all of their teeth, compared to only 4 percent of adults between 18 and 65. Older Americans also face extensive periodontal disease, a major cause of tooth loss. Faced with these findings, NIDR has expanded oral health research with the elderly and is collaborating with the National Institute on Aging and the Veterans' Administration in an oral health research and promotion and disease prevention project.

(e) National Institute of Diabetes and Digestive and Kidney Disease

The National Institute of Diabetes and Digestive and Kidney Disease (NIDDKD) conducts and supports research and research training in diabetes, endocrinology, and metabolic disease; digestive diseases and nutrition; and kidney, urologic, and blood diseases.

Diabetes, one of the Nation's most serious health problems and the largest single cause of renal disease, affects 11 million Americans at an annual cost of $14 billion. Nearly 10 percent of the elderly are believed to be diabetic.

(f) National Institute of Neurological and Communicative Disorders and Stroke

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) supports and conducts research and research training on the cause, prevention, diagnosis, and treatment of hundreds of neurological and communicative disorders. This involves basic research to understand the mechanisms of the brain and nervous system and clinical research.

Most of the disorders studied by NINCDS result in long-term disabilities and involve the nervous system (including the brain, spinal cord, and peripheral nerves), muscles, hearing, and hearing communication. Of particular concern to the elderly is research on stroke, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis, and the dementias, including Alzheimer's disease.

Stroke, the Nation's third-leading cause of death and most widespread neurological problem, primarily affects the elderly. New drugs to improve the outlook for stroke victims and surgical techniques to decrease the risk of stroke currently are being studied.

(g) National Institute of Allergy and Infectious Diseases

The National Institute of Allergy and Infectious Diseases (NIAID) with basic and clinical applications, focuses on two main areas: Infectious diseases and diseases related to immune system disorders.

Influenza can be a serious threat to older adults. NIAID is supporting and conducting basic research and clinical trials to develop treatments and improved vaccines for high-risk individuals from influenza. Since older persons also are particularly vulnerable to hospital-associated infections, NIAID research is leading to a vaccine for protection against one of the most common, difficult to control, and often fatal infections, P. aeruginosa.

(h) National Eye Institute

The National Eye Institute (NEI) conducts and supports research and research training about the prevention, diagnosis, treatment, and pathology and diseases and disorders of the eye and visual system. Glaucoma, cataracts, and aging-related maculopathy, which are of particular concern to the elderly, are being studied by NEI. Some of this research is intended to serve as a basis for future outreach and educational programs aimed at those at highest risk of developing glaucoma.

(i) National Institute of Arthritis and Musculoskeletal and Skin Diseases

The newly established Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) investigates the cause and treatment of a broad range of diseases including the many forms of arthritis, osteoporosis, and others which often are not fatal, but can be costly and cause great hardship for the elderly. This is particularly important to the almost 50 percent of all persons over the age of 65 who suffer from some form of chronic arthritis. About 24 million Americans are estimated to have osteoporosis, most of them elderly.

Research advances are being made on rheumatoid arthritis using recombinant DNA technology while bone metabolism is a key area being emphasized in osteoporosis research.

(j) National Center for Nursing Research

The National Center for Nursing Research (NCRN) conducts, supports, and disseminates information about basic and clinical nursing research through a program of research, training, and other programs. Research related to the elderly includes depression among patients in nursing homes to identify better approaches to nursing care, physiological and behavioral approaches to combat incontinence, initiatives in areas related to Alzheimer's disease, osteoporosis, pain research, and the ethics of therapeutic decisionmaking.

(B) NATIONAL INSTITUTE OF MENTAL HEALTH

As one of three institutes of the Alcohol, Drug Abuse, and Mental Health Administration, the National Institute of Mental Health (NIMH) is involved in extensive research relating to Alzheimer's and related dementia and the mental health of the elderly. NIMH has discovered a protein specific to Alzheimer's which shows promise of being a positive diagnostic marker for the disease. Research into amnesia is increasing knowledge about Alzheimer's disease and other dementia, and on the extent of structural change in the brain as well as the neurochemical aspects of the disease.

(C) GERIATRIC TRAINING

Essential to effective, high quality, long-term and other health care for the elderly is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support was relatively unrestricted and unfocused, aimed at increasing the numbers of all types of health care professionals.

By the mid-1970's, this generalized effort had proven successful and Congress then focused on particular problem areas in the supply of health care professionals, such as geographic and specialty shortages. For example, special trainee and residency programs were established for preventative, family, and general internal medicine, physician assistants and minority health education.

Congress now is beginning to focus more attention on training and education for geriatric care although funding still is limited. The Health Professions Special Education Initiatives Program has been established by Congress to carry out high-priority initiatives in the national interest. Funding has been awarded to schools and other institutions which train health professionals for special educational training programs in geriatrics, health economics, health promotion and disease prevention, and computer-simulated medical procedures.

Under this initiative, geriatric education centers (GEC's) provide short-term multidisciplinary faculty training, curriculum, educational resource development, and other assistance in affiliation with other educational institutions, hospitals, nursing homes, Veterans' Administration hospitals and community-based centers for the elderly. Many GEC's also serve as geriatric evaluation units which provide clinical training. Congress also has initiated a new program under the Public Health Service Act for traineeships and fellowships to initiate in-depth training of faculty in geriatrics for training of future health care providers in geriatrics.

The Senate Special Committee on Aging also has been working for years to develop support for increased geriatric research and training. In 1987, Senator Heinz joined Senators Sasser, Durenberger, Kerry, and Glenn in introducing the "Centers of Excellence in Geriatric Research and Training Act of 1987" which would provide for the development of academic leaders in geriatrics.

2. Issues and Legislation

(A) ALZHEIMER'S DISEASE

For the last several years, Congress has become increasingly concerned about the serious and growing problems of Alzheimer's disease and related dementias. This progressive and irreversible degenerative brain disease is the fourth-leading killer in the United States, affecting an estimated 2.5 to 3 million persons, about two-thirds of all of the cases of dementia. The cost of care and treatment for Alzheimer's patients is estimated at up to $48 billion annually. For the most rapidly expanding segment of the elderly population, those over age 85, the chance of developing dementia is estimated to be 20–30 percent, compared to 7 percent for those age 75–84, and 1 percent for those age 65–74. As the prevalance of dementia escalates in the coming decades, so, too, will the costs—financial, physiological, emotional, and personal.

Congressional consideration of Alzheimer's disease has focused on increased funding for research on the causes, diagnosis, and treatment of the disease. However, no dramatic fix is expected for dementia in the near future, so concern now also is centering on the cost and ways of providing care for its victims.

Most of the federally funded research into Alzheimer's disease is being carried out by the National Institute on Aging, National Institute of Neurological and Communicative Disorders and Strokes, the National Institute of Allergy and Infectious Disease, the National Eye Institute, the National Center for Nursing Research, the National Institute of Mental Health, and the Administration on Aging. The Administration on Aging has supported research and demonstration programs to develop and strengthen family and community-based care for Alzheimer's disease victims.

A great deal of progress has been made recently in the understanding of the cellular and chemical basis of the disease. There is evidence that Alzheimer's disease is associated with an enzyme deficiency and abnormal neurons. Other avenues being explored include a slow virus, an abnormal protein, a genetic defect, a defect in calcium regulation inside the nerve cell, and an accumulation of aluminum in the brain.

Research into treatment of the disease has focused on testing drugs for treating Alzheimer's major symptoms—loss of memory and intellect. No drugs yet have been tested that might stop the underlying progressive process of the disease. Many of the drugs under investigation increase the amount of acetylcholine in the brain. A recent test of a promising drug called tetrahydroaminoacridine (THA) on a small group of patients was thought to reverse symptoms, mainly those related to memory loss. Further studies, at a cost of up to $4 million, were planned in public and private research, but they were discontinued in 1987 at the request of the Food and Drug Administration after the discovery of serious side effects.

The Alzheimer's Disease Research Centers, established by Congress in 1984, are an important component of the national effort to find a cause and cure for this disease. Since funding began in 1984 through grants from the National Institute on Aging (NIA), the centers have established special units for clinical and basic research as well as behavioral studies of Alzheimer's and related disorders. The 10 centers, based mostly at universities and hospitals, also train scientists and health care providers, and fund new research projects.

Guidelines for the centers were developed by NIA along with the National Institute on Mental Health, the National Institute on Neurological and Communicative Disorders and Stroke and the National Institute of Allergy and Infectious Diseases. They were funded at $11 million in fiscal year 1987 and will receive $12 million in fiscal year 1988.

In 1986, Congress passed the Alzheimer's Disease and Related Dementias Services Research Act of 1986 as part of the Omnibus Health bill (Public Law 99-487). Many consider this to be a landmark piece of legislation in that it directs researchers to develop the services needed by individuals with Alzheimer's disease and related dementias and their families. It also established within the Department of Health and Human Services (DHHS) the Council on Alzheimer's Disease to coordinate research on Alzheimer's disease and related dementias and the care of individuals with dementia.

The following table provides information on Federal funding for dementia research from 1981 through 1988 at the National Institutes of Health, the National Institute of Mental Health and the Administration on Aging.

TABLE 4.—FEDERAL FUNDING LEVELS FOR DEMENTIA RESEARCH

[In millions of dollars]

	NINCDS	NIA	NIAID	NIMH	NCI	DRR	VA	NEI	AOA	Total
Year:										
1981	5.4	5.1	1.4	4.7						16.6
1982	6.2	8.5	1.3	4.8						20.8
1983	8.7	11.9	1.0	5.0			1.9			28.5
1984	11.7	21.5	1.3	5.6		0.7	1.2		0.2	42.2
1985	12.8	28.8	1.2	8.6	0.53	1.0	2.0		1.2	54.9
1986	15.0	32.9	1.2	8.8		1.7		0.50	0.8	59.2
(GRH)	13.4	32.7	1.2	8.4	.57	.87				57.1
1987	18.6	42.0	1.4	10.0		2.0		.6	1.2	75.8
1988	19.9	54.9	1.5	10.7		2.2		.6	91.7	91.7

Key to Research Institutes:
AOA—Administration on Aging;
NEI—National Eye Institute;
NINCDS—National Institute of Neurological, Communicative Disorders and Stroke;
NIA—National Institute of Aging;
NIAID—National Institute of Allergy and Infectious Diseases;
NIMH—National Institute of Mental Health;
NCI—National Cancer Institute;
VA—Veterans Administration;
DRR—Division of Research Resources.

Source: National Institutes of Health and National Institute of Mental Health.

In addition, the Budget Reconciliation Act for 1986 (Public Law 99-509), authorized up to 10 Medicare demonstration projects, with an appropriation of $40 million over 3 years, through which a limited number of Alzheimer's patients would receive benefits not previously covered by Medicare. These services must meet the specific needs of Alzheimer's patients and may include case management, adult day care, mental health services, outpatient drug therapy, respite care, and other home- and community-based services.

(B) OSTEOPOROSIS

Osteoporosis is another major debilitating health problem for an estimated 24 million Americans—half of all women over age 45 and 90 percent of all women over age 75. The disease, characterized by chronic loss of bone mass, leads to an increased risk of hip, neck, and wrist fractures, immobility, disability, and sometimes, death. Medical costs, now estimated at $10 billion annually, will increase significantly as the population ages and incidence increases.

Most of the approximately 245,000 hip fractures suffered by individuals over 45 in 1985 were attributable to osteoporosis. This fracture is one of the most catastrophic of all because it requires a longer hospital stay, may involve a hip replacement, and may result in increased risk of death. Researchers at a 1987 NIH workshop on osteoporosis agreed that early detection and treatment of osteoporosis may prevent many of the hip fractures that occur in the United States each year.

However, before definitive treatment for preventing or reversing osteoporosis can be found, a great deal of research still needs to be done. This includes studies of basic bone biology and bone remodeling related to osteoporosis; improved therapies to increase bone mass; better screening methods to measure bone density; estrogen therapy; bone homeostasis and calcium intake, absorption, and excretion; and the effect of exercise on bone.

The latest scientific consensus on osteoporosis recognizes estrogen and calcium deficiencies as the major causes of postmenopausal osteoporosis while certain drugs could be precipatory agents. However, scientists also agree that calcium cannot substitute for estrogen in preventing the accelerated bone loss that occurs in the 8–10 years following menopause.

Other possible research subjects include concurrent estrogen and progesterone therapy, calcium and fluoride compounds, the use of calcitonin from salmon, and studies of calcium loss among astronauts.

(C) GERIATRIC TRAINING AND EDUCATION

Although the Federal Government is beginning to recognize the current and future need for health care professionals trained in geriatric care, it has yet to appropriate significant funding for geriatric education and training.

The comprehensive report to Congress required by the Health Research Extension Act of 1985 on health personnel needed to meet the health needs of the Nation's elderly through the year 2020 was published in 1987. Its findings concerned the projected elderly population and its needs; anticipated personnel, education, and training needs; and financing. It stressed that, although the population over age 65 will increase rapidly through and beyond the year 2020 and a substantial increase in health personnel trained to meet their needs will be necessary, the specific numbers and type of requirements cannot be determined many years in advance. The report therefore recommended continuous monitoring on the changing health and chronic disability status of older persons, and developments in research, technology, treatment, health care, service delivery, and financing. This ongoing assessment is necessary in order to determine the direction and scope of future needs and project the numbers and types of personnel needed.

The report cited that the population over 65 years of age is expected to increase by about 2 percent a year in the coming decades, with the over age 85 population increasing by about 3 percent a year, compared to 1 percent a year increase for younger persons. This greatly expanded older population will require a wide range of health and other services, many of which should help them to remain functionally independent and at home longer.

It is expected that most of the care given to older persons will continue to be a part of the regular practices of health care practitioners but may increase to as much as two-thirds of that practice. Primary care practitioners in family and internal medicine are expected to continue to provide most of the medical care for the aged. The elderly's need for medical services may more than double by 2020 if their current rate of chronic conditions, functional status, and use of health services is maintained.

It is also anticipated that family members and friends will continue to be key caregivers for the elderly which substantially reduces the need for more formal care and institutionalization. But these caregivers usually also need assistance in order to continue their responsibilities.

Although the number of health care practitioners is expected to increase in the next few decades, the number of those that are specifically prepared to serve older people will be far short of the need unless specialized geriatric training for health professionals is greatly expanded. From aides to primary care physicians to geropsychiatrists, health practitioners with training in geriatric care should know about the special conditions and needs of older persons, and have up-to-date knowledge about the most effective ways of preventing and managing the diseases and disabilities older adults experience.

The most serious shortage is in the number of faculty members and other leaders that have specialized backgrounds in aging and geriatrics who can develop and teach undergraduate, graduate, in-service, and continuing geriatric education programs. The report stated that only 5 to 25 percent of the teaching faculty and researchers estimated to be needed to develop sufficient education training programs are currently available. Therefore, the report strongly recommended that the first priority must be to greatly expand the number of faculty members and other leaders to plan, develop, guide, and provide the training, consultation, and research needed for geriatric education and training.

The report also recommended that education and service programs should give special attention to high priority services such as home, community-based, and nursing home services, rehabilitative care and health promotion and disease prevention activities. Special attention was also recommended for high-risk groups such as Alzheimer disease patients and the very frail elderly.

The report found that the most effective way of providing multidisciplinary geriatric training was through collaborative arrangements between academic institutions and providers. Financing has come from many sources, including State, local, and private funds and Federal programs. The report recommended that financing of geriatric education and training programs continue to come from multiple sources and be targeted on strengthening proven approaches. It was also recommended that Medicare and other health care financing programs emphasize alternative training approaches such as in-service training and continuing education in geriatrics.

Finally, the study found many gaps in the information that is available about the health services the elderly receive and the status of related training and education programs. It was recommended that ongoing studies be continued to develop additional data for future analyses and more specific recommendations.

(D) LEGISLATION

Although a number of bills involving Alzheimer's disease were introduced in the 100th Congress, only the appropriations bill and S.J. Res. 15 (Public Law 100-68), which designated November 1987 as "National Alzheimer's Disease Month," were approved during 1987.

However, the Older Americans Act Amendments of 1987 (Public Law 100-175) authorized the Director of the National Institute on Aging to conduct clinical trials on the efficacy of using therapeutic agents to treat Alzheimer's disease, to retard the progression of symptoms of the disease, or to improve the functioning of Alzheimer's patients.

(1) NIH Appropriations

The President's fiscal year 1988 budget proposal would have reduced significantly the Federal commitment to biomedical research by funding NIH at $5.6 billion—$600 million below appropriations for fiscal year 1987. In addition, the administration proposed to carry over $334 million of 1987 appropriations from fiscal 1987 to 1988. Congress rejected both proposals.

Congress continued support for biomedical research is reflected in the continuing resolution for fiscal year 1988 appropriations (Public law 100-202), which provides funding for NIH at a level of almost $6.7 billion, an increase of almost $500 million over 1987 and the largest budget in the history of the NIH. Of this amount, $448 million is designated for AIDS research. The total appropriation should fund 6,100 new and competing research grants.

Both the House and Senate Appropriations Committees emphasized in their reports (H.R. 3058, H. Rept. 256, S. Rept. 189) the need for an expanded effort and the inclusion of increased funding for Alzheimer's research. The House report, in designating additional funding to help close gaps in what is known about Alzheimer's disease, indicated that NIA should do additional research into the epidemiology of Alzheimer's, the identification of risk factors and developing diagnostic instruments and procedures for the disease. Incorporated into the Senate appropriations bill was a bill introduced by Senator Heinz, S. 1045, to appropriate an additional $2.8 million to the National Institute on Aging—$2 million was to be available to the Alzheimer's Disease Research Centers and $800,000 was to be used for clinical trials to test promising drugs to arrest the progression of, and treat Alzheimer's disease and related dementias.

(2) NIMH Appropriations

The continuing resolution also provides $254 million for fiscal year 1988 for mental health research by the National Institute of Mental Health, an increase of $19 million over fiscal year 1987. The House Appropriations Committee also indicated in its report that additional funds were included for NIMH to develop assessment and treatment models for dementia, identification of the cost-effectiveness and possibilities of home and community-based and institutional services, evaluation of ways to reduce stress for family caregivers and assessment of specialized care units.

(3) Geriatric Training

The continuing resolution for fiscal year 1988 also provided $12.5 million for geriatric training programs. Of this, $9.6 million is for geriatric training centers and $2.9 million is for geriatric training of health professionals. This represents about 6 percent of the total appropriation for health professions.

3. PROGNOSIS

Within the past 50 years, there has been an outstanding improvement in the health and well-being of the American people. Once deadly diseases have been controlled or eradicated and the survival rates for victims of heart disease, stroke, and cancer have improved dramatically. Many directly attribute this success to the efforts of our Nation's medical and research community which has been possible because of the Federal Government's longstanding commitment to the support of biomedical research.

Now, as Congress grapples with the persistent Federal budget deficit, the Nation is also confronted with the current and impending costs of caring for rapidly increasing numbers of persons afflicted with two deadly and devastating diseases—Alzheimer's and AIDS. Increased resources and consistent Federal support is essential in order to follow promising research to unravel the cause, develop treatments, and possible prevention of these and many other costly diseases, such as cancer and diabetes, which have so far been incurable.

Also, with the projected phenomenal increases in our country's over age-85 population, study after study has called for tremendous increases in the number of health professionals trained in geriatric care. While Congress has recognized and initiated programs to meet this need, the Federal commitment for funding has been very limited and may continue to be in the face of budget constraints.

In 1988, the administration is expected to again propose budget cuts for biomedical and clinical research, both in appropriations and the number of grants funded. As in the past, Congress is anticipated to reject these proposals and to continue its commitment to health research—with close scrutiny of progress and promise; and sustained and increased Federal financial support.

Chapter 9

LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private medigap insurance. Many elderly persons and their families pay the full costs out-of-pocket, making long-term care the single greatest threat to the financial security of older Americans and many of their families.

Neither significant public nor private improvements in long-term care financing and delivery are on the immediate horizon. The reluctance to implement new long-term care initiatives can be attributed to three factors: First, the 6 million older Americans who need long-term care are a relatively new phenomenon—with no tradition to help mobilize congressional interest or action. Second, the enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform. Third, no current consensus exists on the best way to finance long-term care.

The need for improvement in long-term care has grown more pressing. A series of hearings held by the Senate Special Committee on Aging in 1985 and 1986 disclosed a new and troublesome trend. It was determined through these hearings that Medicare beneficiaries are being discharged from hospitals "sicker and quicker," in large part because of the implementation of the Medicare prospective payment system (PPS). More importantly, these sicker beneficiaries are being discharged into the already strained long-term and sub-acute care system. Therefore, many Medicare beneficiaries are unable to obtain the continued care they often need after hospital discharge.

Federal initiatives to provide long-term care are lacking. The theory behind implementation of PPS was that patient length of stay in costly hospitals would be decreased and that greater amounts of less costly continued care would be provided in the house or nursing home setting. This substitution is occurring, but the Health Care Financing Administration (HCFA) under the Department of Health and Human Services (DHHS) appears to be limiting reimbursement for those substitute services. In the face of enormous Federal deficits, few observers expect the Congress to tackle a major new long-term care initiative in the near term.

This year saw the passage in both the House and the Senate of catastrophic health care legislation. Although the benefits provided in both bills focus on services associated with acute catastrophic illness, not long-term coverage of chronic illnesses, there are provisions in both Senate- and House-passed versions that begin to address the Federal role in the financing and delivery of long-term care services.

Private initiatives alone are unlikely to solve more than a small portion of the problem. The experience of private insurers to date has been disappointing. Long-term care insurance policies have not caught on with the American public, especially among those young enough to purchase insurance when it is more affordable. Employers, too, have shown a reluctance to offer a new long-term care benefit, though there are now available several group plans offered by insurance companies.

A. BACKGROUND

1. TYPES OF LONG-TERM CARE

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (like nursing homes) to noninstitutional settings such as adult day care centers and a person's own home. Community-based long-term care typically encourages a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education. The great majority of long-term care services are provided by family members. Studies have estimated that between 60 percent and 80 percent of the care received by the impaired elderly is provided by relatives and friends who are not compensated for the care they provide.

Long-term care services incorporate the needs of two different types of patient. Some long-term care services meet the health care needs of patients who recently have been discharged from a hospital, while other patients with chronic conditions require care in a nursing home or other facility for an extended period of time.

Access to long-term care by patients discharged from hospitals is a growing problem, particularly under Medicare's prospective payment system. While the problem of access to needed post-hospital care is not new, it has worsened under the incentives of PPS.

The second category of long-term care patients is the more traditional patient, those with functional disabilities, mental disorders, and other nonacute ailments who require maintenance or custodial care over long periods of time. Long-term care for these patients is characterized by extended medical, personal, social, and psychological care at home or in institutions. The need for long-term care coincides not with particular medical diagnoses, but rather with chronic physical or mental disabilities that impair functioning.

Chronic conditions are problems of aging and are responsible for a large portion of the Nation's health expenditures. More than four out of five persons 65 and older have at least one chronic condition and multiple conditions are common in the elderly. However, most older persons are able to live independently in spite of these conditions. According to the 1982 data from the National Long-Term Care Survey, about 19 percent of older persons living in the community report that they no longer can carry on normal activities because of chronic conditions. For the 1982 population of persons over age 65, the leading chronic conditions were arthritis, hypertensive disease, hearing impairments and heart conditions.

Unlike acute illnesses, which usually occur suddenly and can be resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status of the patient. Although chronic conditions occur in persons of all ages, their incidence, particularly when it results in disability, increases with age. A significantly higher proportion of persons 65 and older than persons under age 65 are limited in their abilities to perform normal daily activities due to a chronic condition.

2. NUMBERS OF PEOPLE RECEIVING LONG-TERM CARE

(A) NURSING HOME CARE

In 1985, nearly 12 million elderly citizens had some limitation of daily activity due to chronic conditions, but only an estimated 1.5 million older Americans were confined to nursing homes. With current utilization, the National Center for Health Statistics estimates that this number will increase by 58 percent from 1978 to 2003 if constant mortality is assumed, and by more than 115 percent if declining mortality is assumed.

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. The majority of persons entering a nursing home stay less than 1 year, and one-third to one-half stay for less than 3 months. The old-old (those 85 and older) show much higher nursing home utilization rates than their younger counterparts. For women 85 years and older, their rate of nursing home use per 1,000 population is 251.2, compared to 15.9 for women 65–74 and 80.6 for women 75–84.[1] A similar pattern exists for men, although their utilization rates are much lower.

Chronic illness can prevent individuals from functioning independently without assistance. In 1985, for those over 65 with a chronic condition, an estimated 5.2 million persons required some assistance in performing the activities of daily living to maintain independence. This figure is expected to reach 7.2 million by the turn of the century, 10.1 million by the year 2020, and 14.4 million by 2050. Other groups requiring some measure of long-term care include the mentally retarded, the developmentally disabled, and the adult chronically mentally ill.

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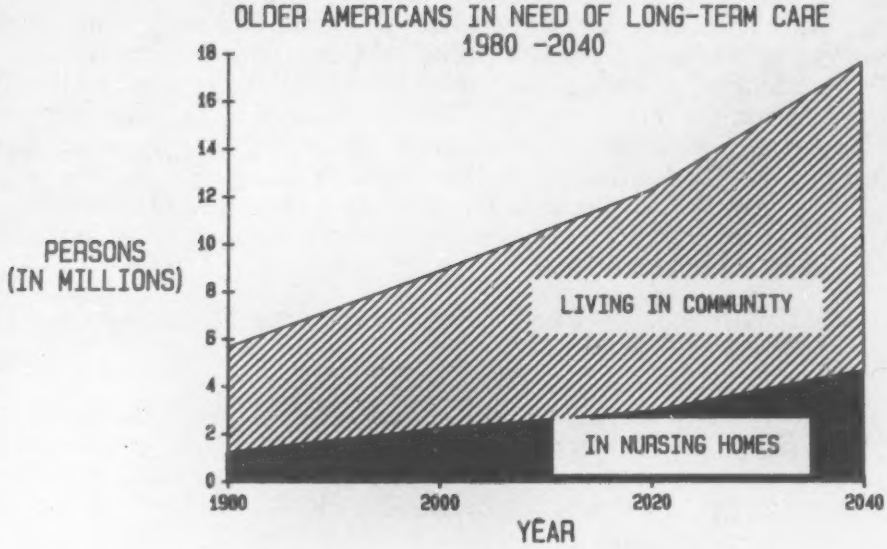
[1] Rice, Dorothy, and Jacob J. Feldman. Living Longer in the United States: Demographic Changes and Health Needs of the Elderly. Milbank Memorial Fund Quarterly/Health Society, v. 61, no. 3, 1983. p. 376.

CHART 1



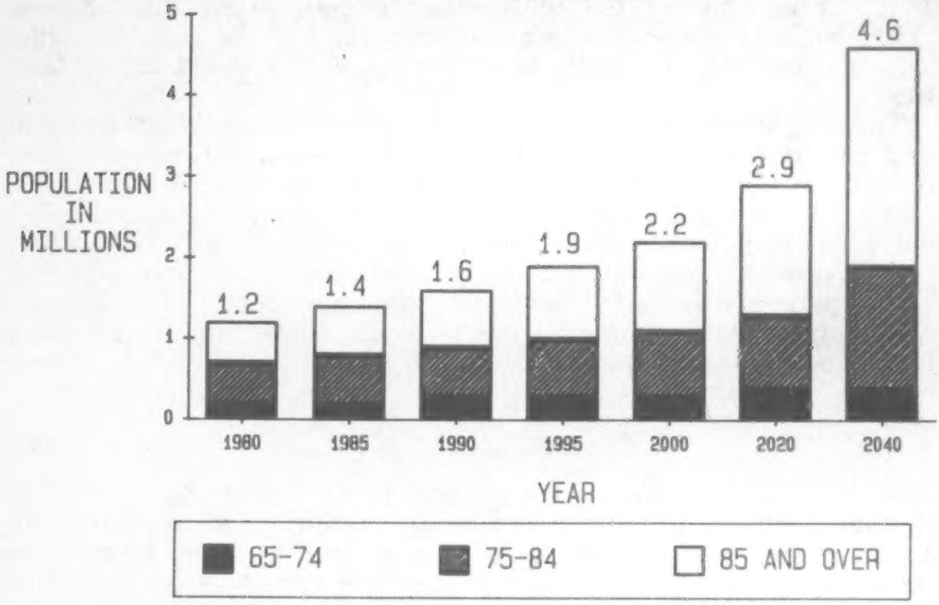
SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

A large portion of noninstitutionalized older Americans may need more extensive long-term care than they receive in the community.

For some of these very dependent people, the nonavailability of beds is a factor preventing their placement in nursing homes. While there are no firm nationwide estimates of the potential needed supply of nursing home beds, experts agree that there are serious shortages of beds throughout the country, with estimates ranging into the hundreds of thousands. Certain localities report a short supply of beds as measured by the numbers of long-term care patients backlogged in acute care hospitals awaiting discharge to a nursing home.

CHART 2

NURSING HOME POPULATION PROJECTIONS
PERSONS 65 YEARS AND OLDER BY AGE GROUP
1980-2040



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

(B) HOME AND COMMUNITY-BASED CARE

For every person 65 and older residing in a nursing home, there are nearly four times as many living in the community requiring some form of long-term care. The 1982 National Long-Term Care Survey estimated that approximately 4.6 million noninstitutionalized elderly Americans—about 19 percent of the over-65 population—had limitations in activities of daily living (ADL's) and instrumental activities of daily living (IADL's). Limitations in ADL's reflect dependence in certain basic self-care functions such as bathing, dressing, and eating, and limitations in IADL's refer to levels of disability in the performance of a daily routine, including shopping, cooking, and cleaning. The 1982 survey found that approximately 850,000 elderly individuals were residing in the community with severe limitations in activities of daily living.

Of the 4.6 million disabled elderly, almost 70 percent relied exclusively on unpaid sources of home and community health care. Almost 1 million received at least some paid care and only 240,000 used paid care only. Of those who received both paid and unpaid care, nearly 41 percent were sole payers for this care, Medicare paid for community care for 8.4 percent of this group and Medicaid paid for about 6 percent. Private insurance pays only about 1 percent of the Nation's long-term care bill.

Health care policymakers have recognized for some time the need to develop a more equitable balance between institutional and noninstitutional care. Most frail elderly in need of assistance with ADL's would prefer to receive that assistance in their homes. While nursing home care is a necessary part of the long-term care system, many feel it should be an option of last resort rather than first.

There is some disagreement among policymakers whether home and community-based care is less costly than institutional care. Clearly in those instances where round-the-clock care is required, nursing home care is the more economical. However, many frail elderly persons need only intermittent care and assistance, which can be provided less expensively than nursing home care. Further, as the patient's needs for care and assistance change over time—as his or her health improves or worsens—home and community-based services are more flexible in adjusting the level of care needed by the patient.[2]

3. Coverage and Financing

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provisions of goods and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing homes.

In 1986 total expenditures for nursing home care were $38.1 billion. Between 1965 and 1983, the annual cost of nursing home care increased 7 percent above the rate of inflation, and was projected to continue rising an average of 4.7 percent above inflation each year between 1983 and 1990. In constant dollars, total nursing home expenditures will increase by more than 50 percent between 1980 and 1990.

About 47 percent of nursing home expenditures were financed by Federal, State, and local governments.

In 1986, Medicaid paid 41.4 percent of the total national nursing home bill. Medicare paid 1.6 percent, private health insurance 0.8 percent, and other private funds 0.7 percent. Direct patient payments accounted for 51 percent of the total. The remaining 4.5 percent came from government payments other than Medicare or Medicaid.[3]

(A) MEDICAID

Coverage

The Medicaid Program, which provides medical assistance for certain low-income persons, excludes most older Americans. Medicaid nonetheless has become the primary source of public funds for nursing home care. Approximately 87 percent of all public expenditures for nursing home care is paid by Medicaid and 48 percent of all nursing home residents are Medicaid beneficiaries. Each State administers its own program and, subject to Federal guidelines, determines the Medicaid income eligibility standard.

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[2] Brian Burwell, "Home and Community-Based Care Options Under Medicaid," in *Affording Access to Quality Care*, ed. Richard Curtis and Ian Hill, (Washington, D.C.: National Governors Association, 1986).

[3] Division of National Cost Estimates, Office of the Acturary, Health Care Financing Administration. National Health Expenditures, 1986–2000. Health Care Financing Review, Summer 1987, vol. 8, no. 4, p. 32.

State Medicaid Programs are required by Federal law to cover the categorically needy, that is, all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most people receiving assistance under the Supplemental Security Income (SSI) program. States also may cover persons who would be eligible for cash assistance, except that they are residents of medical institutions, such as skilled nursing facilities (SNF's) or intermediate care facilities (ICF's).

In addition, States may, at their discretion, cover the medically needy, that is, persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for medical care. Thirty-two States have medically needy programs that cover the elderly. These State variations mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

To control costs and to provide a range of community-based services to the Medicaid-eligible population, many States have applied to the Department of Health and Human Services (DHHS) for section 2176 Medicaid waivers. Congress established these waivers in 1981, giving DHHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a SNF or an ICF. Services covered under the section 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration's support for the section 2176 waiver program, as is discussed later in this chapter.

(2) Expenditures

Medicaid expenditures for nursing home care in 1987 are estimated to have been approximately $17.3 billion, up from approximately $16 billion in 1986.[4] Medicaid financed 42 percent of total nursing home expenditures.

To illustrate the extent to which Medicaid finances nursing home care, in fiscal year 1985, 21.8 million people received Medicaid benefits. Of that number 2.5 percent received skilled nursing facility care, and 3.8 percent received intermediate care facility services. Yet, of fiscal year 1985 vendor payments, 13.5 percent were for SNF care and 17.4 percent were for ICF services.[5]

Medicaid expenditures have been growing rapidly since 1972, and expenditures for nursing home care are the largest and fastest growing component. (See chart 8-3.) Increasing numbers of elderly nursing home residents account for a portion of this growth, but the costs of nursing home care has grown at twice the rate of beneficiary growth. For example, the number of ICF residents (not mentally retarded) grew by 3.0 percent between fiscal year 1984 and 1985, while the cost per resident grew by 7.7 percent, nearly twice the growth rate.[6] The growth in costs for SNF benefits is even more dramatic: The number of recipients actually declined by 2.2 percent during this period while costs per resident rose by 7.7 percent.

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[4] Ibid.

[5] Ibid.

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In fiscal year 1986, Federal Medicaid expenditures for home health care were $1.35 billion, accounting for less than 3 percent of total Medicaid spending. In 1982, home health benefits constituted more than 1 percent of total Medicaid expenditures in only nine States. One State, New York, spent 78 percent of all Medicaid home health dollars.[7]

Because Medicaid expenditures consume 10–15 percent of State budgets, many States are seeking to control the growth of their nursing home population and their obligated Medicaid expenditures. As many as 26 States made changes in nursing home reimbursement policies to reduce costs in 1981 and 1982, and most States now use a form of prospective reimbursement. Other initiatives used to contain Medicaid nursing home expenditures include limits on the number of Medicaid-licensed beds, pre-admission screening programs, and a greater emphasis on home and community-based care.

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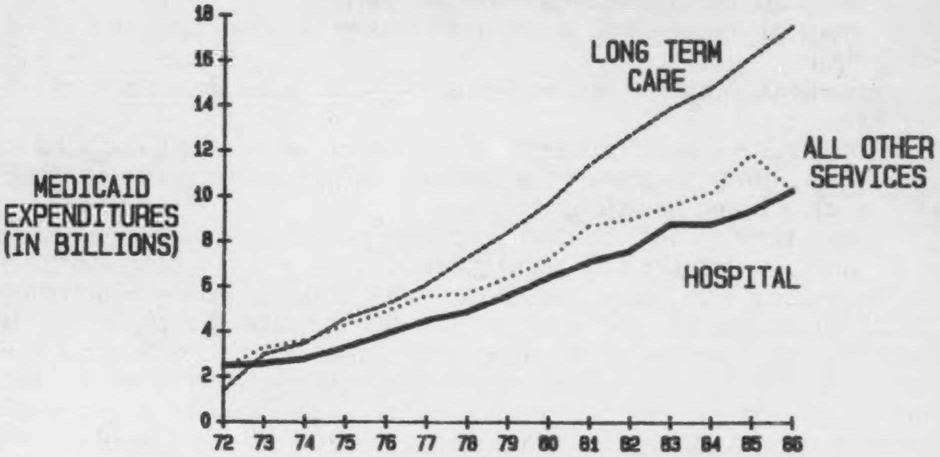
[6] Congressional Budget Office, 1987.

[7] Health Care Financing Administration, Medicaid Statistics Branch, 1986.

CHART 3

GROWTH IN MEDICAID EXPENDITURES
1972-1986



Source: U.S. Health Care Financing Administration, 2082 Medical Care Statistical Report, January 14, 1987

(B) MEDICARE

(1) Coverage

The Medicare Program, which insures almost 98 percent of all older Americans without regard to income or assets, does not cover either long-term or custodial care. Primarily, it provides acute care coverage for those 65 and older, particularly hospital and surgical care and accompanying periods of recovery. For example, Medicare covers up to 100 days of SNF services following a hospital stay of at least 3 consecutive days. Further, in order to receive reimbursement under Medicare, the patient must be in need of skilled nursing care on a daily basis for treatment related to a condition for which he or she was hospitalized. The SNF benefit is subject to a daily patient copayment after the 20th day of care. In 1987, the copayment was $65 per day, rising to $67.50 in 1988. The program pays for neither intermediate care facility services nor custodial care in a nursing home. For those persons receiving SNF benefits, Medicare covered an average of 27 days of care in 1984.

Even though Medicare coverage of home health care is only for short periods of care and only for treatment of an acute care condition or for post-acute care, the Medicare home health benefit is the fastest growing component of the Medicare Program. Below is a brief description of Medicare's home health benefit; developments with regard to this program are discussed in greater detail in chapter 8.

Home health services covered under Medicare include the following:

—part time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

—physical, occupational, or speech therapy;

—medical social services provided under the direction of a physician;

—medical supplies and equipment (other than drugs and medicines);

—medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

—part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must need part time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, such as deductibles or coinsurance, for covered home care. There is no statutory limit on the number of home health visits covered under Medicare, but according to HCFA, home health care should generally be available for just a few weeks. In 1984, Medicare covered an average of 27 home health visits.

In addition to these SNF and home health care benefits, Medicare covers a range of long-term care services, and especially home care services, for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, therapy services, medical social services, home health aide services, physician services, counseling, and short-term inpatient care. Medicare paid $15 million in benefit payments for hospice care for fiscal year 1985, $35 million in fiscal year 1986, and $68 million in fiscal year 1987.

While Medicare coverage of long-term care services is restrictive and limited, older Americans apparently believe it includes basic long-term care services. In fact, a recent survey by the American Association of Retired Persons (AARP) found that of older persons surveyed, 79 percent believed that Medicare would pay for part, if not the entire cost, of their nursing home care.

(2) Expenditures

Medicare expenditures for long-term care generally have been small. In fiscal year 1986, Medicare's contribution to SNF care was only $607 million, less than 2 percent of total public and private spending for nursing home care and less than 1 percent of total Medicare spending.

Medicare payments for home health care comprise less than 3.3 percent of total program outlays. For fiscal year 1986, total reimbursements for Medicare home health services were $2.5 billion. Medicare's home health benefit expenditures are the fastest growing component of the Medicare Program.

(C) TITLE XX

(1) Coverage

Title XX of the Social Security Act authorized reimbursement to States for social services, now distributed via the Social Service Block Grant (SSBG). Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are not appropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the Title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated, and as a result, data concerning the extent to which Title XX now supports long-term care are very limited. According to a Department of Health and Human Services analysis of the States' fiscal year 1986 pre-expenditure reports, home care services, which may include homemaker, chore, and home management services, were to be provided to adults and children by virtually all States.

(2) Expenditures

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of Title XX funds—States are provided relative freedom to spend Federal Social Service Block Grant funds on State-identified service needs. Legislation in the 98th Congress permanently increased the annual ceiling for all Title XX activities to $2.7 billion, effective in fiscal year 1984. In fiscal years 1985 1986, and 1987, the appropriation level was again $2.7 billion; the 1988 appropriation is $2.75 billion.

(D) THE OLDER AMERICANS ACT

(1) Coverage

The Older Americans Act (OAA) carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities, and social services. While the OAA funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by

Congress. Each OAA area agency on aging is required to spend a portion of its supportive services allotment on home care services.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount provided under Medicare and Medicaid. The OAA services, however, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid. In some cases, OAA funds may be used to assist persons whose Mediciare and Medicaid benefits have been exhausted or who are ineligible for Medicaid.

In-home services represent an expenditure priority for the title III program. According to a 1984 National Data Base on Aging survey of 121 area agencies on aging, about one-quarter of their funds were directed at in-home services. While a substantial portion of these funds were spent on the home-delivered meals component (which receives a separate appropriation under the OAA), an almost equal portion of the total spent on in-home services was devoted to housekeeping, personal care, and chore services.

(2) Expenditures

Unlike the Title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of title III funds for supportive services, for congregate nutrition services and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies on aging some flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Total fiscal year 1988 appropriations for title III are $835 milion, of which $345 million is for congregate nutrition services, $269 million is for supportive services and senior centers, $75 million for home-delivered nutrition services, $140 million for USDA commodities and $4.7 million for in-home services.

(E) PRIVATE INSURANCE

(1) Medigap

In 1984, between 64 percent and 75 percent of the noninstitutionalized elderly had some type of supplemental medical insurance coverage. Although these policies vary, individual and group medigap insurance was the most common type of coverage. According to a 1985 AARP/Gallup survey, former employers paid some, if not all supplemental insurance premiums for about 40 percent of all retirees. These policies are typically designed to supplement Medicare's coverage of acute care costs, not long-term care costs.

To illustrate, most policies provide comprehensive coverage for Medicare copayments, but very few provide coverage for needed services and products that Medicare does not cover. Some medigap policies cover the daily copayment from the 20th to the 100th day of an approved stay in a Medicare SNF. Others provide coverage for skilled care (as defined by Medicare) in a certified facility for stays of 100–365 days, or longer. The value of medigap coverage for long-term care, however, is very limited. These policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs. Premiums for medigap coverage vary greatly within States and across the country. For example, premiums in New York State for 1986 ranged from $119 to $1,003 and in Wisconsin, from $152 to $1,578.

A 1982 survey conducted by the Health Care Financing Administration and SRI International, a private research firm, found that people who need supplemental coverage the most because they cannot afford the costs of major illnesses are the least likely to have it. Therefore, while medigap policies provide some needed protection for many of our Nation's elderly, those who have the greatest need for coverage often go without it.

(2) Long-term Care Insurance Policies

In mid-1986, only about 200,000 people held private long-term care insurance. Assuming most policyholders are over 65, this represents less than 1 percent of the Nation's elderly. This method of financing long-term care has been receiving a great deal of attention lately—not only because of growing concerns about public program expenditures, but also because the costs of long-term care represent the largest out-of-pocket health expense for the elderly.

In 1987, the General Accounting Office (GAO) released a report on the private long-term care insurance market. GAO reviewed 33 policies offered by 25 insurers, accounting for a sizable portion of the policies sold nationwide. There was considerable variation among the policies—the indemnity benefit amounts (fixed dollar amount paid per eligible day of coverage) ranged from less than $10 to $120 per day. Premiums charged varied from $20 to $7,000 per year, offering varying levels of coverage at different ages. Duration of benefits differed widely, too—from 6 months to 6 years of nursing home care and 10 days to 6 years for home health services. GAO found that in general, premiums increased with age, and insurers offered indemnity benefits that were not indexed to keep pace with inflation. Most of the policies GAO reviewed contained restrictive clauses (such as requirements that policyholders be admitted to nursing homes within 30 days of hospital discharge) and limitations (such as exclusions from certain diseases) that might prevent some policyholders from collecting benefits.

However, GAO also found that more insurers offer custodial care benefits, and nearly half of the policies reviewed provide benefits for all levels of nursing home care and home care benefits. Most of the policies let consumers choose the length of the waiting period and daily indemnity amounts from among serveral options. Finally, most of the policies guarantee renewability. However, since the insurers who guarantee renewability reserve the right to raise premiums for a class of insureds, some elderly policyholders on fixed incomes could be priced out of the market.

In 1985, at congressional request, the Department of Health and Human Services (DHHS) established a Task Force on Long-Term Health Care Policies. In 1987, the task force released its report to Congress and the Secretary of DHHS. The report contained recommendations for encouraging the development of a broad-based market for affordable long-term care policies while providing reasonable protection for consumers. Recommendations included expansion of the market through employer-sponsored long-term care insurance, the creation of tax incentives to encourage participation by both employers and insurance companies, long-term care financing through vested pension funds, the development of new approaches to eligibility requirements for long-term care insurance benefits, and efforts to educate the public on its need for this type of coverage.

A number of barriers have been cited as impediments to the development of long-term care policies. Many insurers are concerned about adverse selection, in which only persons more likely to need long-term care will buy insurance for it. Induced demand—beneficiaries using more services because they have insurance and/or shifting from unpaid to paid providers for their care—is another concern. Further, many people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

Despite the problems inherent in this area, many believe that significant market development may occur in the next several years. Not only is there growing interest on the part of some insurance companies, but many States, faced with mounting Medicaid nursing home expenditures, have expressed interest in having such coverage made more widely available.

(F) OUT-OF-POCKET COSTS

While the cost of long-term represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

Older persons and their families pay for more than one-half of the costs of nursing home care. The proportion of total nursing home costs paid out-of-pocket has increased by about 20 percent from 1975 to 1985. During that same period, the portion of nursing home costs paid by Medicaid has decreased. As mentioned above, while the amount that Medicaid pays for nursing home care has been increasing (306 percent between 1975 and 1985), so has the amount paid out-of-pocket—420 percent between 1975 and 1985.

The vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 percent and 80 percent of the elderly persons living in the community who need long-term care receive all of the care they need from family and friends. The remaining 20–30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.[8] Between 60 percent and 95 percent of home care is given by family and friends.

This home care is rendered to 1.2 million disabled elderly persons by 2.2 million friends and relatives. In 75 percent of the cases, care is given via a live-in arrangement. Ninety percent of the caregivers are low- or middle-income.[9]

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[8] Callahan et al., 1980; Christianson and Stephens, 1984; Liu et al., 1986; as cited in Stone, Cafferata, Sangl, Caregivers of the Frail Elderly: a National Profile.

[9] (Stone, Cafferata, Sangl, Caregivers of the Frail Elderly: A National Profile.)

Home care is generally a less expensive option for the elderly, but about 14 percent have out-of-pocket costs from home care that range from $360 to $1,680 per year, depending on the level of disability.[10] These out-of-pocket costs are only for home care; they do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

The cost of community-based care pales in comparison with the cost of nursing home care. The price of a year in a nursing home ranges from $12,000 to $50,000; the cost at even the lower end of this range is beyond the resources of most older Americans. Thus, many elderly people must spend their savings and become eligible for Medicaid soon after they enter a nursing home. Currently, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicare. A recent study released by the House Select Committee on Aging shows that this spend-down occurs on the average within 13 weeks after admission for the single older American.

B. ISSUES AND LEGISLATION

1. Nursing Home Care

The demand for nursing home services is expected to increase based on projections of growth of the population of older Americans. The 65 and older age group is expected to increase from the present level of 25 million to 36 million by the year 2000. More notably, the 85 and over population (those most at risk of needing institutional care) is expected to increase from 2.5 million at the present time to 5 million in the year 2000—an increase of 100 percent.

Issues surrounding nursing home care likely will become the focus of increased congressional and public interest in the years to come. Following is a discussion of several of the pertinent nursing home issues of the past year, including: Nursing home quality of care, Medicaid coverage for the impoverished aged, including Medicaid spend-down and spousal impoverishment, the personal needs allowance for Medicaid nursing home residents, and the long-term care ombudsman program under the Older Americans Act.

(A) NURSING HOME QUALITY OF CARE

Quality of care in nursing homes has been an item of concern and interest to the elderly and their advocates for a number of years. Several investigations and studies, including a 2-year investigation (completed in 1986) by the Senate Special Committee on Aging, a report by the Institute of Medicine, and most recently a report commissioned from the General Accounting Office by Senator John Heinz, have found that thousands of frail elderly citizens live in nursing homes which fail to provide care adequate to meet even their most basic health and safety needs. Legislation finally was passed in 1987 to implement many of the recommendations of the various studies and aging advocacy organizations. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) OBRA 1987 contains extensive nursing home quality care provisions that will take effect over the next 2½ years. This legislation will be outlined in greater detail below, following a discussion of the findings that led to its passage.

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[10] 1982 National Long-Term Care Survey.

In 1982, in response to congressional concern about controversial nursing home regulations proposed by the Health Care Financing Administration (HCFA), HCFA commissioned a study from the Institute of Medicine (IoM) of the National Academy of Sciences. According to the contract, this study was to "serve as a basis for adjusting Federal (and State) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible." The study was begun in October 1983 and released in 1986. It concluded that the quality of care and quality of life in many nursing homes are unsatisfactory, and that a stronger Federal role is essential to improve the quality of care. The study made a number of recommendations to strengthen and improve the current Federal regulations that have been incorporated into the 1987 law. These recommendations include the elimination of the distinction between SNF's and ICF's, the use of intermediate sanctions to enforce compliance with regulations, and the strengthening of residents' rights.

Both the GAO report and the Special Committee on Aging's investigation found many of the same problems. For example, the Aging Committee disclosed that nursing home inspection reports from HCFA revealed that in 1984, more than one-third (3,036) of the Nation's 8,852 certified SNF's failed to comply with the most essential health, safety, and quality standards of the Federal Government. About 1,000 (11 percent) of the SNF's violated three or more of these standards. GAO found that 41 percent of SNF's and 34 percent of ICF's nationwide were out of compliance during three consecutive inspections with one or more of the 126 skilled or 72 intermediate care facility requirements considered by experts to be most likely to affect patient health and safety. Penalties or sanctions to enforce compliance were found to be severely lacking.

In 1987, Senator Mitchell and Representatives Dingell, Waxman, and Stark introduced nursing home reform legislation (H.R. 2270, H.R. 2770, and S. 1108). Components of these bills were included in OBRA 1987. The provisions are written in great detail, similar to agency regulations, leaving little to interpretation. Many contend that this reflects congressional distrust of HCFA and the administration on this issue. Earlier in 1987, HCFA proposed new rules to address nursing home quality concerns, in what some believe was an attempt to illustrate that legislation was not needed.

Among the provisions of the act are:

Definition of a nursing facility.—Eliminates the distinction between SNF's and ICF's as of October 1, 1990, and repeals a requirement that States pay less for ICF services than for SNF services; as of October 1, 1990, all nursing homes participating in either Medicare or Medicaid must meet the same requirements for provision of services, the rights of residents, staffing and training, and other administrative matters.

Requirements for care.—As a condition of participation in Medicare or Medicaid, facilities must, at least once a year, conduct a comprehensive assessment of each patient's ability to perform such every day activities as bathing, dressing, eating, and walking. Results of such assessments will be used in a written plan of care, describing how a person's medical, psychological, and social needs will be met.

Residents' rights.—Requires that nursing home residents be informed both orally and in writing of their legal rights, including the rights to: Choose a personal physician, and be informed in advance about treatment; be free from physical or chemical restraints; have privacy in accommodations, medical treatment, written and telephone communications; confidentiality of personal and clinical records; and have immediate access to a State or local long-term care ombudsman.

Staffing requirements.—As of October 1, 1990, all nursing facilities participating in Medicare or Medicaid must have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty, 24 hours per day, 7 days per week. All nursing facilities with more than 120 beds must employ at least one full-time social worker.

Training for nurse aides.—All nurse aides in facilities participating in Medicare or Medicaid must complete an approved training course (75 hours) that includes instruction in basic nursing skills and personal care skills; cognitive, behavioral, and social care; and residents' rights. States must maintain a registry of individuals who have successfully completed such a course, and must also report instances in which an aide has committed acts of resident neglect or abuse (although the aide will have appeal rights).

Survey and certification process.—States are responsible for ensuring compliance with new requirements (except State-owned facilities, which would be monitored by the Federal Government). Each facility is subject to an unannounced "standard survey" on a statewide average of at least one per year, but no less than every 15 months. Facilities found to be delivering substandard care will be subject to an "extended" survey. However, States may impose sanctions based solely on the results of a standard survey.

States also must maintain procedures and staff adequate to investigate complaints of violations of requirements, and to monitor on-site, on a regular basis, the compliance of facilities found in violation or suspected of violations.

Enforcement process, Intermediate sanctions.—If a State or the Federal Government finds a facility out of compliance and the deficiencies immediately jeopardize the health or safety of the residents, the State or DHHS must take immediate action to correct the deficiencies through the appointment of temporary management or terminate the facility's participation in the Medicare or Medicaid Program.

If the facility deficiencies do not immediately jeopardize the health or safety of its residents, the State or DHHS may impose one or more intermediate sanctions, terminate the facility's participation, or both. Intermediate sanctions include denial of payment for new Medicare or Medicaid admissions, civil penalties for each day of noncompliance, appointment of temporary management for the facility, and emergency authority to close the facility and transfer its residents.

Facilities found out of compliance for 3 consecutive months are automatically subject to denial of payment for new admissions. Facilities remaining out of compliance for three consecutive standard surveys and found to be delivering subtandard care are subject to automatic denial of payments and to on-site monitoring by State officials.

(B) MEDICAID COVERAGE FOR IMPOVERISHED AGED

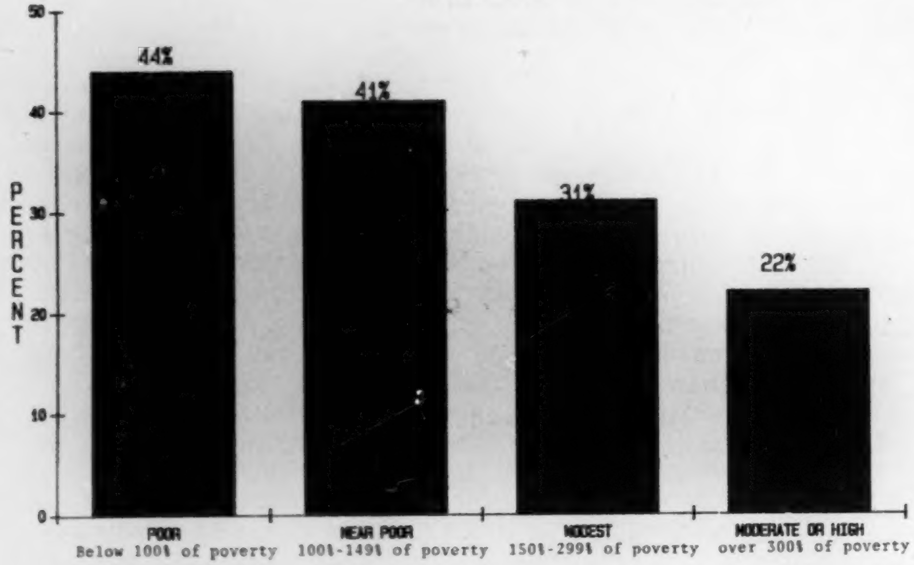
Medicaid was created as the health care safety net for the Nation's poor. On balance, it has served them fairly well. There are, however, 2.2 million elderly persons whose incomes are too high to allow them to qualify for Medicaid under traditional income tests, but far too low to allow them to afford the health care they need. Medicaid currently covers only 36 percent of America's aged poor.

There are only two ways to qualify for Medicaid: Categorical eligibility is linked to eligibility for Supplemental Security Income (SSI), while "medically needy" eligibility is determined by spending down through medical costs to 133 percent of the Aid to Families with Dependent Children (AFDC) level. Unfortunately, in both cases the individual's income must be far below poverty. For example, the SSI income eligibility limit is $111 less than poverty ($336) per month for a single person and $199 less than poverty ($504) per month for a couple.

Medicaid coverage for this population group is especially important since the elderly and disabled poor have large health care needs. As chart 4 illustrates, the incidence of elderly reporting fair or poor health increases as their income level declines. (Note. The 1987 poverty line for single elderly is $5,393 per year, and $6,802 per year for elderly couples.) Death rates among the elderly poor are 50 percent higher than for other Medicare beneficiaries. Despite their greater health needs, they receive 35 percent fewer physician visits, use 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital.

CHART 4

PERCENT OF ELDERLY REPORTING FAIR TO POOR HEALTH BY INCOME: 1984



Source: National Health Interview Survey and Supplement on Aging, 1984

A particularly important concern over the past few years has been the issue of Medicaid spend-down for nursing home care. While there is a great deal of variability among States' Medicaid programs and income eligibility levels, nursing home residents—and often their spouses—must impoverish themselves before they become eligible for Medicaid coverage. According to the Department of Health and Human services, about one-half of the persons receiving Medicaid Services, coverage for their nursing home care became eligible after they entered the nursing home.

A recent report from the House Select Committee on Aging revealed that 7 in 10 elderly persons living alone (and 9 million of the 27 million noninstitutionalized elderly in this country live alone) are impoverished after 13 weeks in a nursing home.[11] Within 1 year of entering a nursing home, more than 90 percent of these elderly are impoverished. Based on income, a person older than 65, living alone, with an annual income between $9,700 and $15,000 (between 200 percent and 300 percent of the poverty level) would be impoverished after only 17 weeks, on average, in a nursing home. The same older person with an income between $6,000 and $10,000 (between 125 percent and 200 percent of the poverty level) would be impoverished, on average, after only 6 weeks in a nursing home.

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[11] U.S. Congress, House Select Committee on Aging, "Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk," Committee Print, 100th Congress, 1st Session, Washington, D.C., U.S. Government Printing Office, 1987.

While the picture is somewhat brighter for elderly couples, more than one-half of the couples are impoverished after one spouse has spent only one-half year in a nursing home. Most often, it is the wife who remains in the community, and she often is left with little or no money with which to meet her own health and other needs.

Generally, when determining Medicaid eligibility, income (such as Social Security checks, pensions and interest from investments) is attributed to the person whose name is on the instrument conveying the funds. In the case of Social Security, the amount attributed to each spouse is the individual's share of the couple's benefit. Therefore, if the couple's pension check is made out to the husband, all of that income is considered his for the purpose of determining Medicaid eligibility. Because the current generation of women whose husbands are at risk of needing nursing home care typically did not work outside the home, they likely have very little income other than their husband's.

The attribution of resources such as certificates of deposit and savings accounts is done similarly. If the resources are held solely by the institutionalized spouse, they are attributed to him or her for purposes of determining Medicaid eligibility. If they are in both spouses' names, they are still attributed to the institutionalized spouse. Medicaid eligibility can be denied to individuals who transferred resources for less than fair market value within 2 years of applying for Medicaid.

Once an institutionalized spouse has been determined Medicaid-eligible, some of his monthly income is reserved for the use of his spouse. When combined with the community spouse's income (if one exists) it allows a maintenance needs level. Under current regulations, the maintenance-needs level may not exceed the highest of the SSI, State supplementation, or "medically needy" standards in the State. According to a survey taken by the American Association of Retired Persons in March 1987, maintenance-needs levels vary widely from State to State—from a high of $632 in Alaska to zero in Oklahoma. Thus, in a State with a maintenance-needs level of $350, if the community spouse's monthly income is equal to $150, the contribution from the institutionalized spouse would be $200.

Both the Senate- and the House-passed versions of the catastrophic health insurance legislation (H.R. 2470) contained provisions to address the issue of spousal impoverishment.

The House-passed version of the bill specifies that in determining Medicaid eligibility, half of the couple's income would be attributable to each spouse. It also provides for a one-time determination of resources, with half attributable to each spouse. The institutionalized person may transfer an amount equal to one-half, or $12,000, whichever is higher, to the spouse, up to $48,000. For example, if the couple has assets worth $20,000, the institutionalized person may transfer $12,000 to the spouse. If they have assets worth $100,000, the institutionalized person may transfer $48,000 to the spouse. If the spouse's share of their assets exceeds $48,000, the excess is attributed to the institutionalized person.

Further, this provision permits the community spouse to keep income equal to 150 percent of the poverty line plus one-half of the couple's income over that amount not to exceed $1,500 per month. It also establishes a national policy on transfer of assets.

The Senate provision, which was offered as an amendment by Senator Mikulski and others, is similar to the House provision except that the spouse is permitted to keep an amount equal to 122 percent of the proverty line plus one-half of the couple's income not to exceed $1,500 per month.

(C) PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nearly 800,000 Medicaid nursing home residents depend on their personal needs allowance (PNA) each month to cover a wide range of expenses not paid for by Medicaid. The current amount of the personal needs allowance is $25 a month—or 82 cents per day. However, with the passage of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the PNA will be increased to $30 per month, effective July 1, 1988. Prior to this, the PNA had not been increased—or even adjusted for inflation—since Congress first authorized payment in 1972. As a result, the $25 PNA is worth less than $10 in 1972 dollars. And although the $5 monthly increase in the PNA is certainly a victory, there is no provision to provide for a cost-of-living adjustment (COLA) in the PNA in subsequent years. Thus, all recipients of Social Security and SSI benefits have received COLA's to their benefits since 1974, except the frailest and most vulnerable—Medicaid nursing home residents.

For impoverished nursing home residents, the PNA represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eyeglasses, clothing, laundry, newspapers, and phone calls. In addition to personal needs, many nursing home residets have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, such as hearing aids and dentures, preventing them from tending to personal needs.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve is bed there. Eve though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the cost and guarantee the nursing home resident a bed to come back to. While the $30 monthly PNA represents an improvement over the $25 monthly PNA, many advocates of the Nation's nursing home residents believe it still is not adequate to meet the needs of most residents.

(D) LONG-TERM CARE OMBUDSMAN PROGRAM

The long-term care ombudsman program began as a demonstration project in the early 1970's as a part of the Federal response to serious quality-of-care concerns in the Nation's nursing homes. These demonstration ombudsman programs were charged with the responsibility to resolve the complaints made by or on behalf of nursing home residents, document problems in nursing homes, and test the effectiveness of the use of volunteers in responding to complaints. As a result of the success of the early programs, Congress incorporated the ombudsman program into the 1978 amendments to the OAA.

Under the OAA, each State is required to establish and operate a long-term care ombudsman program. These programs, under the direction of a full-time State ombudsman, have responsibilities built upon those outlined above. The programs are to: (1) Investigate and resolve complaints made by or on behalf of residents of long-term care facilities, (2) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities, (3) provide information as appropriate to public agencies regarding the problems of residents of long-term care facilities, and (4) provide for training staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program. The 1981 amendments to the OAA added the requirement that ombudsmen serve residents of board and care homes.

The primary role of long-term care ombudsmen is that of consumer advocate, and they are not limited to responding to complaints about the quality of care. Problems with public entitlements, guardianships, or any number of issues that a nursing home resident may encounter are within the jurisdiction of the ombudsman. A major objective of the ombudsman is to establish a regular presence in long-term care facilities, so that they can become well-acquainted with the residents, the employees, and the workings of the facility. This presence is important as it helps the ombudsman establish credibility and trust. Further, because about one-half of nursing home residents have no family, many may have only the ombudsman to speak on their behalf.

There are now more than 600 local ombudsman programs throughout the Nation. According to the Administration on Aging—the Federal agency responsible for the OAA and the ombudsman program—from fiscal year 1984 to fiscal year 1985, the number of complaints handled by programs accross the country increased more than 18 percent—from approximately 71,000 to 84,000. Of these, 62 percent were either partially or fully resolved.

Despite the program's growth and effectiveness, Federal support, in terms of funding and statutory requirements has been inadequate. The Institute of Medicine's report on the quality of care in nursing homes noted that the ombudsman programs varied widely in their effectiveness, and stated the need to make improvements to the program in the future.

To address these concerns, the Older American Act Amendments of 1987 (Public Law 100-175) contained several provisions to strengthen and improve the long-term care ombudsman program. Among the provisions is a requirement that States provide access to facilities and to records, and immunity for good faith performance of duties. Further, they must provide adequate legal counsel and representation to ombudsmen if it is needed. Each State must also ensure that any willful interference with the official duties of ombudsmen is unlawful, and that retaliation or reprisals against facility residents and others who complain or cooperate with ombudsmen are unlawful.

The bill also requires States to provide for the training of all personnel in the ombudsman program (including volunteers) in Federal, State, and local laws with respect to long-term care facilities in the State, in investigative techniques, and any other areas the State deems appropriate. The Commissioner of the Administration on Aging is required to submit a report to Congress by December 31, 1989, on the findings and recommendations of a study on the long-term care ombudsman program, its impact on issues and problems affecting residents of long-term care facilities, and the effectiveness of recruiting, supervising, and retaining volunteers. Also, for the first time, a separate authorization of funds for the ombudsman program is established, with an authorization of $20 million in fiscal year 1988.

2. Home and Community-Based Care

There has been growing interest on the part of Congress to expand the Federal role in providing home and community-based care for chronically ill elderly. Much of the interest has centered on expanding Medicaid's section 2176 Home and Community-Based Waiver Program, the programs authorized by the Older Americans Act and the Medicare Program.

The need for this type of care is great. More than 4 million elderly Americans have limitations in activities of daily living, and roughly one-third of the Nation's nursing home residents do not need to be institutionalized. Finding ways to meet the needs of these people in home and community settings is a growing national concern. This section outlines current Federal issues relating to the Section 2176 program and the Older Americans Act as well as various proposals now before the Congress aimed at expanding Federal support to better meet the long-term care needs of the elderly in their homes.

(A) SECTION 2176 WAIVER PROGRAM

Prior to 1981, Federal regulations limited Medicaid home care services to the traditional acute care model. To counter the institutional bias of Federal long-term care spending, Congress in 1981 enacted new authority to waive certain Medicaid requirements to allow States to broaden coverage for a range of community-based services and to receive Federal reimbursement for these services. Specifically, Section 2176 of the Omnibus Budget Reconciliation Act of 1981 authorized the Secretary of DHHS to approve 2176 waivers for home and community-based services for individuals who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility. Community-based services under the waiver include case management, homemaker/home health aide services, person care services, adult day care services, habilitation services, respite care, and other community-based services. As of 1987, 46 States had established waiver programs, which now are serving roughly 60,000 elderly and disabled persons.

HCFA has expressed concern that the home and community-based waiver program may actually increase Federal expenditures for long-term care. While home and community-based care may be less costly on an individual recipient basis, aggregate Medicaid costs may increase if the program results in the provision of a new range of services to persons who would not otherwise use nursing homes/institutional care funded by Medicaid. Previous research and demonstration efforts in home and community-based care suggest that achieving program savings depends on how effectively waiver services are targeted. HCFA has argued that targeting the services to the population most at risk from entering an institution is quite difficult, if not impossible.

In an effort to restrict the program, HCFA in 1984 imposed a variety of impediments on States. However, because of the popularity of the waivers among the States, as well as a need to develop alternatives to institutionalization, Congress, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, enacted various legislative proposals to ensure that the Section 2176 waiver option would continue to be available.

The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) also includes provisions aimed at expanding the program. The act creates a new waiver authority under which the States can provide home and community-based services. Under the waiver, the requirements for the program to be statewide, comparability, and income and resource rules applicable in the community are waived. Expenditures for skilled nursing facility services, intermediate care facility services, and home and community-based services for individuals 65 and older, may not exceed a projected amount, which is determined by comparing the amount spent in the base year for such services increased by factors which take into account increases in the cost of goods and services, the over-75 population, and the intensity of services. It is anticipated that several States will establish more expansive home and community-based care programs under this new waiver authority.

(B) HOME CARE UNDER THE OLDER AMERICANS ACT

Various social services, including in-home services, currently are provided under title III of the Older Americans Act. But the need for in-home services is so great that this year's reauthorization of the expanded in-home services authorized under title III. The Older Americans Act Amendments of 1987 (Public Law 100-175) adds a new part D to title III, authorizing grants to States for nonmedical in-home services for frail older persons. These services include assistance in such areas as bathing, dressing, eating, mobility, or performance of daily activities such as shopping, cooking, cleaning, or managing money. In-home respite care for families and visiting and telephone reassurance are additional examples of allowable services.

Funding for this new program is aimed at assisting persons who are ineligible for other Federal programs. Currently, many frail elderly persons who are not poor enough to qualify for Medicaid and who do not meet Medicare's medical-related criteria need in-home services to live independently. These new OAA services are targeted strictly at the elderly and may be provided without the health-related restrictions of Medicare and the income tests of Medicaid.

(C) NEW INITIATIVES UNDER CONSIDERATION

A number of bills have been introduced in the 100th Congress to provide expanded home and community-based services to meet the chronic care needs of the elderly. The key initiatives are as follows:

Long-term home care.—Representative Pepper and Senator Simon have introduced the most expensive and far-reaching home care bill that Congress has seen to date. The Medicare Long-Term Home Care Catastrophic Protection Act (H.R. 2762/S. 1616) would establish for the first time a long-term home care benefit under Medicare for the elderly and children. All disabled workers, children, and elderly who need assistance with at least two of the five activities of daily living (such as eating, dressing, or using the toilet), as well as technology-dependent children, would qualify for home care benefits. Since the benefit primarily is aimed at meeting long-term care needs as opposed to post-acute care needs, patients no longer would need to be homebound and in need of intermittent care for Medicare to cover home health. The cost of this initiative—about $6 billion a year—is financed by upper income workers and employers by eliminating the cap of $45,000 on income that is subject to the Medicare payroll tax. According to the sponsors of the legislation, only 5 percent of workers would be affected by the elimination of the cap.

Adult day care.—Senators Melcher, Bradley, and Heinz introduced the Adult Day Care Act of 1987 (S. 1839), which provides up to 100 days of adult day care a year under Medicare, with a $5 daily copayment, for medically or mentally impaired adults who otherwise would require institutional care. Services also would be available to individuals who need assistance in at least two activities of daily living. Adult day care is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective group setting on a less than 24-hour care basis. Using an individually tailored plan of care for each participant, this program can help meet many of the needs of functionally impaired adults. According to the legislation, a multidisciplinary group of professionals would provide a wide range of health and health-related services under medical supervision.

Respite care.—A Medicare respite care benefit was included in the House version of the catastrophic health care bill (H.R. 2470), which is discussed in more detail below. In addition, the 1987 reconciliation bill establishes a respite care pilot program in New Jersey for low-income elderly. Families frequently want to take care of their ailing kin at home, but the burden of providing care to an elderly dependent family member can, at times, be overwhelming. In many cases, relatives must carefully juggle their caregiving tasks with demanding full- or part-time jobs. In 1982, an estimated 2.2 million persons in the United States cared for frail elderly persons. Often the caregivers themselves are elderly and frail. According to one study, more than 50 percent of the caregivers are over 60 and 18 percent are over 70. Giving family members a break from the day-to-day burdens of caring for their loved ones can help keep families intact.

3. LONG-TERM CARE AND THE CATASTROPHIC HEALTH CARE LEGISLATION

The House and Senate versions of the Medicare Catastrophic Loss Prevention Act (H.R. 2470) provide little coverage for long-term care, although many would argue that long-term care is the most catastrophic of all health expenses. For those elderly spending more than $2,000 annually on out-of-pocket medical expenses, the cost of nursing home care absorbs more than 80 cents of every dollar spent over and above $2,000. While both versions of the legislation provide for expansion of Medicare's skilled nursing facility and home health benefit, these benefits are designed to rehabilitate benficiaries after an acute illness—not to provide services to those needing long-term care as a result of a chronic illness. (For a detailed analysis of the catastrophic legislation, please see chapter 8.)

There were, however, provisions in both versions of H.R. 2470 that provide a starting point for the issue of financing and delivering long-term care for Medicare beneficiaries. The House-passed version of the bill provides for up to 80 hours per year of in-home benefits for chronically dependent persons as a respite for caregivers. To be eligible for this benefit, a Medicare beneficiary would have to be unable to carry out two or more activities of daily living without the assistance of a primary caregiver who is living with the beneficiary and is unpaid. Services offered under this benefit would include homemaker or home health aide, personal services, and nursing care provided by a licensed practical nurse. The benefit would expire December 31, 1991.

The respite care coverage is the only provision in either version that provides for the actual delivery of services—the other long-term care-related provisions concern studies or research on long-term care services. Both the Senate and the House bills contain a provision to require the Secretary of the Department of Health and Human Services (DHHS) to evaluate and report to Congress on the various adult day care services being provided throughout the United States. The Senate provisions was offered as an amendment to the original bill by Senator John Melcher.

Both bills contain provisions mandating studies of long-term care, although the studies differ. The Senate bill would require the Institute of Medicine (IoM) to submit to Congress by October 1, 1989, a study on the options for the private funding of a portion of long-term care, including Federal incentives to facilitate this funding, options for private sector long-term care coverage, and the effectiveness and cost of community-based long-term care services. Senator Melcher successfully offered an amendment to the bill that would expand the scope of the IoM study to include a review of the impact that various approaches to financing long-term care would have on access to those services by various groups, such as minorities, children, and women. The Senate version also contains a provision requiring the Secretary of the Treasury to conduct a study and make recommendations with respect to tax policies to encourage the private financing of long-term care. The study in the House version of H.R. 2470 would direct the Secretary of DHHS to conduct additional research on the delivery and financing of comprehensive long-term care for Medicare enrollees.

Both House and Senate versions of this legislation contain provisions that would establish a bipartisan congressional commission to make recommendations regarding Federal programs for comprehensive health care. Within 6 months of enactment, the commission would report to Congress with findings and recommendations for appropriate legislative initiatives regarding comprehensive long-term care for the elderly and disabled. This provisions was offered as an amendment in the Senate by Senators Melcher and Chiles.

Despite claims that catastrophic health care legislation would be signed into law in 1987, no final bill was sent to the President for his signature by the end of the year. However, final action on H.R. 2470 was expected in 1988.

C. PROGNOSIS

Congress can list a number of achievements in 1987 regarding long-term care. Among these, the passage of nursing home quality reforms, the inclusion of spousal impoverishment provisions in the catastrophic legislation, and the increase in the personal needs allowance rank high. Perhaps more importantly, 1987 was a year in which Congress began to seriously consider the issue of long-term care. As the Senate Special Committee on Aging and Congress grapple with finding the proper Federal role in financing and delivery of long-term care services, they will be looking for answers to questions such as, "Who is receiving long-term care services and from whom? Who needs long-term care and where is the best place to provide it? What will the needs of future generations be? Who should pay the costs of long-term care and how can the proper balance between public and private financing be achieved?" Volume III of Developments in Aging has been dedicated to providing information which should help answer these questions.

In the months ahead, growing importance will be placed on exploring alternatives to traditional long-term care. For example, a number of demonstration projects funded by the Office of Research and Demonstration at the Health Care Financing Administration are aimed at testing the effectiveness of community-based and in-home delivery systems for long-term care services. These projects include social health maintenance organizations, which provide for the integration of social and health care services, and respite care for impaired elderly. Similar projects are taking place at the State and local levels, as well as at colleges and universities. The Senate Aging Committee anticipates hearings and possible legislation designed to foster the development of creative alternatives to institutional care.

Faced with intense pressure to decrease the deficit and balance the Federal budget, Congress is unlikely to pass legislation that would finance the costs of long-term care in 1988. However, 1988 is a Presidential election year, and many aging advocacy organizations are urging Presidential candidates to put the issue of long-term care on their agendas. Therefore, the success of any future legislative intiatives regarding this issue likely will depend, in part, on the outcome of the 1988 elections.

Chapter 10

HOUSING PROGRAMS

OVERVIEW

The housing and shelter needs of the elderly have been a primary concern in the area of aging social policy for a number of years, and during the last two decades the Federal Government has substantially increased its response. The question today is "Has this response peaked?"

Program activity at the Department of Housing and Urban Development (HUD) has been on a substantial downward slope since fiscal year 1981. The largest decline has been in the assisted housing category, down from $25 billion in fiscal year 1981 to $7.9 billion appropriated for fiscal year 1988—a reduction of nearly 70 percent. Because approved funding of these programs is scheduled to be spent over a long period of time—20, 30, or even 40 years—cuts in budget authority are slow to result in reductions in outlays or actual spending. Thus, in spite of substantial reductions in budget authority, outlays on assisted housing programs increased from $5.75 billion in fiscal year 1981 to an estimated $9.5 billion in fiscal year 1987. The number of households receiving aid increased from about 3.2 million in 1981 to 4.4 million in 1987. These increases, however, are attributable to funding made prior to the Reagan administration as well as the shortening of contract terms. This results in the appropriation of requested budget authority being postponed to future years, therefore increasing the number of households presently assisted by a given quotient of authority.

During 1987, the Congress passed the first major housing legislation since 1980. This legislation, the Housing and Community Development Act of 1987 (Public Law 100-242) provides a 2-year reauthorization of most housing and community development programs at a cost of $15 billion in fiscal year 1988 and $15.3 billion in fiscal year 1989. This figure includes approximately $7.2 billion for low-income assisted housing in fiscal year 1988 and $7.3 billion in fiscal year 1989.

The need for elderly housing continues to increase, to a large extent because of a growing elderly population. Current demographic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75. From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent and those headed by persons over 75 will increase 52 percent. In 1995, 21.4 million households will be headed by Americans over 65.

In addition, there is a growing need for special living arrangements and support services for older persons. An increasing number of frail elderly—those over 75 years of age with mild to moderate impairments in their activities of daily living—are aging in place in Federal housing projects and in private residences. This stark fact raises serious questions on ways to best provide a supportive environment where social, physical, and emotional needs are met without jeopardizing the independence of older Americans.

Rapidly escalating housing costs have contributed to the need for Federal programs. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses. Housing costs for the elderly are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans. Elderly renters comprise about one-third of all elderly households, and two-thirds of renters are single. This problem is particularly acute for them, because they pay a far larger share of their incomes for housing than homeowners. Recent data indicate, for example, that an elderly woman living alone spends nearly 50 percent of her income on housing. Some 2.3 million elderly households spend more than 35 percent of their incomes on housing.

The majority of the elderly have equity in their homes that could help in meeting their housing costs. Three out of every four elderly persons own their homes; 80 percent of them mortgage free. These are often elderly suburban homeowners with low incomes and for many, their home is their only asset. These factors have contributed to the growing interest in innovative housing arrangements, such as home equity conversion plans, and in strategies for allowing the "overhoused" elderly homeowner to take advantage of more appropriate, maintenance-free housing through such alternatives as life-care communities.

Although the need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget reductions.

A. FEDERAL HOUSING PROGRAMS

1. General Background

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. One approach has been to provide housing directly through new construction programs and rental assistance payments aimed at providing adequate and affordable housing for those who could not otherwise afford it. A second and more costly approach has been to provide tax incentives for house construction and home ownership through deduction of mortgage interest and property tax payments from individual gross income and through a variety of tax provisions favoring real estate transactions.

Heightened concern with old-age housing issues has its origins in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for legislation to be enacted that would eventually target the elderly as beneficiaries for such housing assistance.

Although low-income public housing created under the Housing Act of 1937 was not intended initially to provide special assistance for the elderly, it began to evolve into one of the principal forms of Federal assistance for low-income older persons in the later 1950's. Prior to 1956, only 10 percent of all the units were occupied by persons 65 years and older. Between 1956 and 1959, however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing units occupied by the elderly increased to 19 percent in 1964 and to 46 percent in 1984. In addition, 1959 saw the enactment of the Section 202 program, the first housing program specifically designed for the elderly.

In the mid-1970's, Congress significantly expanded Federal housing assistance to the elderly. The Section 202 elderly housing program was reinstated after being phased out in the late 1960's and the Section 8 housing assistance program was enacted. Although not specifically targeted to the elderly, Section 8 has become one of the two major sources of assisted housing units occupied by those 65 years and older. In 1987, Section 8 provided 854,000 units of assisted housing for the elderly. Another major source, public housing, provides roughly 500,000 units for elderly families. As of October 1987, there were approximately 2,225 Section 202 projects nationwide, with 127,582 occupied housing units. About 12,000 units were occupied by the physically or mentally handicapped.

(A) SECTION 202

The Section 202 program is the primary Federal financing vehicle for constructing subsidized rental housing for elderly and handicapped persons. Under the program, the Federal Government makes direct loans to private, nonprofit sponsors for use in developing Section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped.

The original Section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10 year period, the program provided construction financing and 50-year loans at 3 percent interest to nonprofit and limited-dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised Section 202 program authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs. The Section 202 loan rate was fixed at 9.25 percent in 1983, in response to rising interest rates; it will be 9 percent in fiscal year 1988. From fiscal year 1974 to fiscal year 1987, approximately

$8.9 billion was reserved, representing almost 4,000 projects and approximately 200,000 units.

The original Section 202 program was successful. Only one project was foreclosed during the 10-year period. The program served mostly middle-income rather than low-income elderly. Since the revised program is used in conjunction with Section 8 program (HUD's major vehicle for the provision of housing to low-income households), it serves a wider range of elderly households.

Under the revised Section 202 program, funds are allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels. In 1983, there were approximately 4.7 million elderly rental households representing about 26 percent of all households in the United States headed by an elderly person.

A review of the Section 202 Elderly Housing Program completed by the General Accounting Office (GAO) in 1985 provided some basic information on how the program is being utilized. Nearly all of the program beneficiaries were single. On average, beneficiaries were 73 years old, white, had lived in their unit/project for about 2.5 years, and had an annual income of about $6,600. Most (82 percent) had very low incomes—below 50 percent of the median income (adjusted for household size) for the areas in which they lived.[1]

Most beneficiaries lived in a one-bedroom unit that rented for an average of $480 per month and contributed about $146 toward this rent. The balance of $334 was paid by the Government through Section 8 rental assistance payments.

GAO found that in the survey sample the housing needs of minority elderly are not being met by the Section 202 program. Minority elderly are on average poorer than white elderly, yet most projects have few, if any, minority residents. Of the 142 projects sampled, 42 percent of the projects (which accounted for about 33 percent of program beneficiaries) had no minority tenants and 70 percent of the projects (with 68 percent of the tenants), had 5 percent or fewer minority tenants. Sixty percent of the minorities in the sample were housed in 13 projects (9 percent of the projects sampled). At each of the 13 projects, more than 50 percent of the tenants were minorities.

(B) PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.4 million units housing more than 3.5 million people. In fiscal year 1987, Federal outlays for public housing were more than $3.5

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[1] The analysis conducted by GAO is based on a review of HUD records for 179 projects at 10 HUD field offices, visits to 47 of these projects, and data on 802 Section 202 projects, obtained from HUD's Computer Underwriting and Processing System. The study was limited to projects primarily serving the elderly.

billion for operating subsidies, construction debts, and major repairs.

The Low-Rent Public Housing Program is the oldest of those Federal programs providing housing for the elderly. Approximately 537,000 units (44 percent) of the Nation's more than 1.4 million public housing units are occupied by older Americans. It is a federally financed program operated by locally established, nonprofit Public Housing Authorities (PHA's). Each agency usually owns its own projects. By law, the PHA's can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Until recently, Federal assistance to public housing projects has been in the form of annual contributions used to defray the PHA's debt. Beginning in fiscal year 1987, funding for development and modernization is provided through capital grants, rather than financing of long-term debt. Originally, funding of capital costs was the only form of Federal public housing assistance. It was assumed that tenants' rents would cover project operating costs for such items as management, maintenance, and utilities. Rents were originally set for each apartment regardless of income, then limited to 25 percent of net income and are now 30 percent of net income. However, tenant rents have not kept pace with increased operating expenses.

Changes requiring greater targeting of benefits to the very low income group (50 percent of area median rather than 80 percent) have also decreased rental revenues for the public housing authorities. As a result, Congress has provided additional assistance to the projects to cover these expenses. Operating subsidies totaled $1.2 billion in fiscal year 1987.

Much of the public housing was built three and four decades ago and is in need of major renovation. Even its stanchest supporters admit that the program has been plagued by mismanagement in some cities and often aggravated by local political interference and patronage. It also is a system that has become home for many chronically unemployed and underemployed people who can ill-afford to pay significantly more in rents to offset the skyrocketing cost of operations and maintenance.

About half of all the units in assisted projects were developed under and continue to be operated within the public housing program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters, including Congress, about the condition of the projects and their management; PHA's about their rising costs and the inadequate funding levels for operation and modernization, and by the Office of Management and Budget (OMB) about ever-burgeoning outlays. Additionally, the managers of the public housing projects continue to raise their concern about the lack of congregate services for their tenants who have aged in place and need supportive services to remain independent.

(C) SECTION 8

(1) Construction/Existing

The Section 8 program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Until 1983, HUD entered into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Authority to enter into new contracts for assistance to new or substantially rehabilitated units was eliminated in 1983 except under the Section 202 program. Payments made to owners and developers under assistance contracts are used to make up the difference between what the rental household can afford to pay for rent and what HUD has determined to be the fair market rent for the dwelling. As of the end of fiscal year 1986, there were 2.1 million units eligible for payment. Of those units, it was estimated by HUD that approximately 47.9 percent were occupied by older persons.

The concern over the Federal deficit has forced the Federal Government to re-assess the cost effectiveness of many social programs, including the new housing construction programs. Section 8 was not designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing, but was structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970's. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's (GNMA) purchase of mortgages under its special function, or by financing from State housing financing agencies or from public housing agencies, both of which obtained funds from sale of tax-exempt bonds. GNMA exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through Stae housing finance agencies by means of the finance adjustment factors which, in effect, raised permissible rents over the fair market rent level. The relatively high subsidy cost arising from both the high rent supplement required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and Congress. Finally, in the Housing Act of 1983, the Section 8 new construction program was repealed except for that attached to the Section 202 program.

While the production component of the Section 8 program has been viewed as unsuccessful, the existing housing component of the Section 8 program generally has been alluded to as a successful form of assistance. Under Section 8 existing housing program, HUD pays the difference between 30 percent of an assisted housing tenant's income and the fair market rent standard for the jurisdiction. In fiscal year 1987, HUD paid approximately $8.1 billion in Section 8 housing assistance of all types to eligible families. This figure includes funding for the voucher program, which appears to be the administration's answer to subsidized housing in the future.

(2) Vouchers

As an alternative to conventional public housing programs, the Reagan administration supports a system under which low-income families receive vouchers similar to food stamps. These enable a family to rent housing in the private market, assisted by a Federal payment transmitted through a local public housing agency to a landlord. The voucher subsidizes the difference between 30 percent of the family's income and the fair market rent of a suitable sized unit, although the actual rent may be more or less than the fair market rent.

The Housing Act of 1983 continued existing Section 8 certificates, but also established a Section 8(o) demonstration voucher program. Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's new Rental Rehabilitation and Development Program. However, 5,000 units were allocated to a free-standing program to provide an opportunity to compare the operation of the voucher program with the Section 8 existing certificate program. The voucher program was permanently authorized by the Housing and Community Development Act of 1987 (Public Law 100-242).

Under the voucher system, also referred to originally as the modified Section 8 existing housing certificate, HUD's contribution also is based on the difference between an established rent payment standard for each market and 30 percent of a new tenant's income. Like fair market rents, the rent standard is set at the 45th percentile of the distribution of rents of standard quality in newly occupied units, and tenant eligibility is based on an income standard of 50 percent of area median income.

The tenant, however, likely will pay more or less than 30 percent of his/her income for rent. HUD's contribution still is based on a 30-percent-of-income contribution, but the rent standard is not necessarily the actual, or maximum, rent. Rather, the rent received by the landlord is based on whatever is negotiated between the tenant and landlord, as in the private market. Thus, if a tenant finds a unit that is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit that is more costly than the rent standard HUD uses, the tenant would have to contribute more than 30 percent of income to make up the rent payment. Another difference between the two programs is the duration of the assistance contract which is limited to 5 years under the voucher program compared to the 15-year duration of the Section 8 existing housing contracts. The HUD appropriations act for 1985 provided $500,000 for HUD's research budget to evaluate vouchers versus 5- and 15-year Section 8 contracts. Preliminary findings by Abt Associates, contractors for this study, show that certificate and voucher holders find units to rent at about the same rate. On average, however, vouchers are more costly for both tenants and HUD.

(3) Rental Rehabilitation and Development

New rental rehabilitation and production programs were enacted under Title I of the Housing and Urban-Rural Recovery Act of 1983 (Public Law 98-181). The programs authorize Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under Section 8), and have greater requirements for local public and private sector investments in the projects, stricter limits on Federal per-unit costs, and greater demonstration of rental housing need by local authorities.

The Rental Rehabilitation Program is formula-based and allocates funds directly to selected cities with populations of 50,000 or more, urban counties, and States for distribution to smaller communities. The program is targeted at lower- and moderate-income families. Rental assistance is provided to very-low income and displaced lower income persons to help them afford the increased rent of rehabilitated units or to move to other housing. This assistance is made available through housing vouchers or Section 8 certificates to local PHA's.

According to HUD, the number of completed units has increased dramatically in the past 2 years. As of July 1987, commitments had been issued for 15,459 projects containing 80,152 units. In 9,437 projects, with 32,857 units, all the rehabilitation construction work had been completed. Elderly tenants account for approximately 11 percent of the occupied units of these buildings.

(D) THE FARMERS HOME ADMINISTRATION

The Housing Act of 1949 authorized the Farmers Home Administration (FmHA), administered by the Department of Agriculture, to make loans and grants to farmowners to construct or repair farm dwellings and other buildings. Amendments to the act made the programs available to rural residents, in general, to purchase or repair homes and for other purposes. The rural housing programs of FmHA are generally referred to by the section number under which they were authorized in the Housing Act of 1949 and its subsequent amendments.

Section 502 loans enable low-income rural residents to purchase or repair new or existing single-family housing. Borrowers may receive interest credit to reduce the interest rate to as low as 1 percent. The loans are repayable over a 33-year period. The loan term may be 38 years for borrowers with income below 60 percent of the area median. The borrowers must be unable to obtain credit elsewhere on reasonable terms.

Section 504 loans are made to rural homeowners who could not afford a Section 502 loan but need funds to make the dwellings safe and sanitary or to remove health hazards. Very-low-income elderly homeowners may qualify for grants or some combination of loans and grants.

With Section 514 loans, farmers or organizations may obtain 33-year loans to provide "modest" living quarters and related facilities for domestic farm laborers. Qualified nonprofit organizations, Indian tribes, and public bodies may obtain Section 516 grants for up to 90 percent of the development cost of such housing.

Under Section 515, developers may obtain 50-year, 1 percent loans to build rental housing for rural reidents or congregate housing for the elderly and handicapped. Except for public bodies, all borrowers must demonstrate that financial assistance from other sources will not enable the borrower to provide the housing at terms that are affordable to the target population.

Section 521 provides for rental assistance payments to borrowers to make up the difference between the tenants' payments and the FmHA approved rents for the housing (financed under Section 514 or Section 515). Borrowers must agree to operate the property on a limited profit or nonprofit basis.

Under Sections 523 and 524, nonprofit organizations and Indian tribes may obtain 2-year loans to purchase and develop land that is to be subdivided into building sites for housing low- and moderate-income families. The sites developed under the Section 523 program are used by low-income families to build houses by the mutual self-help method. No limits are placed on the method of financing or constructing the housing built on Section 524-financed sites.

Section 533 authorized FmHA to make grants to organizations for rehabilitating rural single family homes, rental properties, and cooperative housing.

2. Issues and Legislation

(A) LIMITING THE FEDERAL ROLE

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in that the Federal Government has been unwilling to treat housing assistance as an entitlement. As a result, many eligible households simply cannot find the assistance they need. Data indicates that the more than 4 million assisted units available at the end of fiscal year 1985 are enough for, at best, 25 percent of those eligible for assistance. Further, while there were 16 million elderly households in 1980, this number is projected to increase to 23 million in the year 2000. This means that the elderly will need 7 million more units in 2000 than they had in 1980—assuming that all elderly households in 1980 were decently housed and that the present housing stock will be maintained.

According to a 1986 report of the National Low Income Housing Coalition, Federal housing efforts have fallen far short of meeting elderly housing needs. In 1984, there were 1.1 million elderly renter households with incomes below the poverty level. Only 444,000, or not quite 40 percent, of these households lived in subsidized housing. The remainder lived either in substandard housing or paid more for housing than they could afford, or both. The Coalition estimates that, at a minimum, a need for housing assistance for almost 700,000 poor elderly need housing assistance. In addition, there are 1.5 million elderly homeowners with incomes below the poverty level. They note that only one small Federal program exists—Section 504, the Farmer's Home Administration program for very-low-income homeowners who need funds to make their homes safe and sanitary or to remove health hazards. This program operates only in rural areas.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget savings. The net effect of these fiscal constraints has resulted in a policy shift by the current administration toward other approaches for meeting the housing needs of older persons. The current administration's program for housing and community development has sought to limit the role of the Federal Government in housing assistance. The main thrusts of the administration's housing assistance policies have been to shrink the growth of the program and to seek less expensive solutions. Since 1981, it has attempted to contain the budgetary growth of housing programs by targeting assistance to those most in need, and relying almost exclusively on direct assistance to households in existing units.

The administration's budget request for HUD-assisted housing for fiscal year 1988 was $3.9 billion, which represented a 50-percent cut from the fiscal year 1987 funding levels. The President's budget proposed elimination of almost all programs that build, rehabilitate, or modernize housing for low- and moderate-income Americans, and would have replaced them with vouchers. More specifically, the President's budget requested no new funding for the Section 202 program, and would have eliminated it after fiscal year 1988. Congress, as in the past, rejected most of the administration's proposals.

In 1987, the first major housing bill in 7 years was sent to the President. This legislation, the Housing and Community Development Act of 1987, passed both Houses of Congress on December 21, 1987 and was signed into Public Law 100-242.

Congress encountered difficulties in enacting this legislation. The conference agreement easily passed the House. However, when it was brought to the Senate floor for the first time in November, some Senators felt the bill was too costly and contributed too heavily to the budget deficit. Consideration of the bill was halted when a procedural question was raised as to whether to waive the budget limits established by a resolution earlier in the year. Although 57 Senators voted to waive the limits, which the bill exceeded by approximately $47 million, the waiver required the support of 60 Senators. The bill returned to conference, and an agreement was subsequently reached.

The Housing and Community Development Act of 1987 authorizes most housing and community development programs for 2 years, at a cost of approximately $15 billion in fiscal year 1988, and $15.3 billion in fiscal year 1989. This legislation holds spending at current levels for the next 2 years for most programs. Of particular interest to the elderly are the bill's provisions relating to HUD-assisted housing, including Section 202, Section 8, and the Congregate Housing Services Program, reverse annuity mortgages, and the prepayment of mortgages. These are discussed in greater detail below.

(1) Section 202

The Section 202 program is the most visible elderly housing program, and it has had its problems and criticisms. While it generally has produced quality and financially viable housing projects for the elderly and the handicapped, it has also experienced some political controversy. These disputes stem from several problems, including the program's high costs of production, the tendency, at least of the original program, to serve primarily moderate- and middle-income elderly, and the draw that the program makes annually on the Federal budget because of its use of direct loans from the Federal Government at reduced interest rates.

There are an average of six Section 202 units for every 1,000 elderly persons in the country and less than one-fifth of a project's units become vacant annually. As a result, there are more than a quarter of a million persons (270,000) waiting to get into the 2,438 Section 202 projects nationwide. Waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

Indeed, the housing needs of several million elderly—housing that is affordable, safe, accessible, and suitable in terms of neighborhood amenities and services—have gone unaddressed. Program cuts have come not only at a time of high demand, but also at a time when demand will probably increase. The enormous projected growth of the elderly population suggests the prospect of rapidly increasing shelter and service needs that the Nation has just begun to recognize.

In 1985, $600 million was appropriated for 12,000 units of Section 202 housing. As part of the President's spending freeze to reduce the Federal deficit, his fiscal year 1986 budget proposed a 2-year moratorium on new assisted housing production. Congress, however, did not agree with this proposal and $631 million was appropriated in fiscal year 1986 for the construction of 12,000 Section 202 housing units. For fiscal year 1987, $593 million was appropriated to fund the construction of approximately 12,000 units of housing for the elderly and handicapped.

The Housing and Community Development Act of 1987 authorizes $622 million in fiscal year 1988 and $630 million in fiscal year 1989 in loans under the Section 202 program. However, the 1987 continuing resolution (Public Law 100–202) establishes the direct loan limitation for fiscal year 1988 at $565.8 million. This amount is intended to provide funding for the construction of approximately 10,990 new Section 202 units. Further, the continuing resolution requires that 25 percent of the loan authority under Section 202 must be used only for handicapped project loans. This represents an increase in the number of units built for the handicapped—and a decrease in the number of units built for the elderly. Because Section 202 is one of the only Federal housing programs where new construction is taking place, it is likely that the program will be the focus of attention of the various groups in need of housing. While most housing advocates agree that the elderly are only one of several segments of the population in need of safe and affordable housing, many feel it is unfortunate that these various groups find themselves competing for scarce housing dollars.

The Housing and Community Development Act contains a provision that provides for priority in HUD's selection of Section 202 projects for those applicants providing replacement housing for 100-unit projects or larger that are owned by a public housing authority and that are used for elderly occupants and are to be demolished. This provision will be in effect until September 30, 1988.

Section 202 has been the target of numerous regulatory and administrative changes, however, which are aimed at making the program more cost effective and targeting assistance to the neediest of elderly and handicapped persons. These recent changes in program direction as well as those continuing policy issues mentioned earlier have been, and will continue to be, the focus of debate in years to come.

(2) Limits on New Construction

The current administration's emphasis on using existing housing is based not only on cost considerations but also on its belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met most efficiently by providing Section 8 certificates or, preferably, vouchers to eligible families for existing rental housing.

The shift from new construction to existing Section 8 was made for a number of reasons. For the first time, substantial use could be made of the existing housing stock, with a consequent reduction in per unit subsidy costs from those incurred in new construction. It was hoped that use of the existing stock would provide recipients of aid with a greater choice of location and housing type, since they would not be restricted to specific, designated developments. A higher income subsidy provided to owners would encourage maintenance of the stock, which otherwise faced deterioration; and improvement of already deteriorated units could be fostered by the rehabilitation program. This was seen as a way not only of increasing household satisfaction but also of promoting racial and income integration. Families could move out of concentrated minority-occupied, low-income areas.

Fear was expressed by opponents of this reliance on existing housing that, in places with low vacancy rates, rents would be driven up for all renters, particularly those of lower income who did not receive a subsidy. Other concerns include that there might be an absolute shortage of standard-quality rental units relative to the number of subsidized households in some localities and even if there were a sufficient number of units, vacant units might not match the needs of particular types of households, such as large families. As the program has operated, further concern has been expressed that if the acceptable rent is held at a relatively low level, it prevents the dispersion of low-income families out of inner-city areas.

The Reagan administration has enjoyed considerable success in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market. The primary emphasis with regard to public housing for the elderly has become preservation, maintenance, and rehabilitation of the existing housing stock.

A large percentage of new construction of housing over the past 10 years has been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

(3) Vouchers

Advocates of the voucher program argue that, like the Section 8 certificate programs, the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost that a new construction program. In their view, it would, on the one hand, provide an incentive to families to search for lower, though standard quality, rental units. On the other hand, it would permit those who valued housing highly to rent better quality or larger units by paying more of their income for rent. Recipients of Section 8 certificates do not have this option. Moreover, since the contract is for 5 years rather than 15, less budget authority need be appropriated in any one year for the same number of assisted families.

The shift to voucher assistance brings some problems for the elderly in need of housing assistance. The voucher system only pays the difference between 30 percent of income and some fair market rent determined for the area. The result has been that some recipients end up paying more than 30 percent of their income for rent. This is especially difficult for the elderly, many of whom are on fixed incomes. In addition, it is uncertain whether the elderly could find housing which meets their special needs, such as accommodation for wheelchairs and grab rails in bathrooms, in the private market.

The voucher system has been met with skepticism by Congress and many housing advocates. Critics of the program point to a shortage of decent low-cost housing in the largest cities. They question whether vouchers will provide real help to those most in need or simply encourage private landlords to increase rents because they know tenants have additional funds available. Since the vouchers are only authorized for 5 years, critics also raise the point that they do not represent a commitment to providing housing for the poor. They believe the budget savings are illusory, since the need will continue and, presumably, additional funds will be appropriated to continue assistance at the end of the 5-year period.

The fiscal year 1985 appropriation act funded 42,000 vouchers, of which 38,500 are incremental and 3,500 for replacement of lost Section 8 and public housing units. Fiscal year 1986 appropriations included 39,500 additional vouchers. In fiscal year 1987, $1.03 billion has been appropriated to fund 53,500 additional housing vouchers. The 1987 continuing resolution (Public Law 100-202) provides $1.167 billion in new budget authority for approximately 49,000 additional housing vouchers for fiscal year 1988. Of that amount, 45,000 are incremental and 4,000 for replacement of lost Section 8 and public housing units.

(4) Tenant Rent Contribution

The Omnibus Budget Reconciliation Act of 1981 reduced the income eligibility limit for almost all applications for housing assistance to 50 percent of the median income in the local area. The previous limit was 80 percent. Only 10 percent of those admitted to units available before the act and 5 percent of those who rented units becoming available after the act could have incomes between 50 percent and 60 percent of median.

The percentage of those with incomes from 50 percent to 80 percent of median admitted to previously available units was increased from 10 to 25 in 1983, but 5 percent was kept for those becoming available after the act became law. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only. The continued eligibility of current tenants with incomes above 50 percent of median was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1984.

There have been complaints that HUD has implemented the 5-percent limitation in such a way as to prevent renting to lower-income (from 50 to 80 percent of median) households in almost all projects. Efforts have been made in the last few years to liberalize enforcement of the provision. The Housing and Community Development Act of 1987 forbids HUD from establishing procedures which totally prohibit admission of lower income families, and instructs it to establish different percentage limitations in the various programs in such a way that the total when aggregated over the entire spectrum of assisted housing programs will meet the percentage limit in the act.

As the funding for Section 202 housing becomes increasingly difficult to obtain, there may be continued efforts by some to focus the very poorest. This may be difficult to do because the program has historically served a more middle- and low-income population.

(5) Cost Containment

Cost containment requirements in the Section 202 program may work to change the program for providing housing with supportive services for the elderly to one of providing only minimal housing. Recent changes made to the Section 202 program to increase the cost effectiveness of the program and allow more units to be built with the same amount of money include: Requirements that Section 8 recipients in Section 202 projects pay 30 percent—instead of 25 percent—of the household's adjusted income for rent, at least 25 percent of the units in a project be efficiencies, and sponsors must limit the size of the units, congregate space, and number of amenities. The establishment of maximum sizes for apartment units and community spaces removes much of the flexibility in design required to meet the changing needs of an aging population. To serve a more frail, elderly population, sponsors need a facility designed with smaller units and more congregate space. Policies of rigidity rather than flexibility may virtually eliminate the possibility of developing a proper facility for an increasingly frail population.

In 1984, the General Accounting Office began a review of the Section 202 elderly housing program. The focus of the study was to examine the effectiveness of HUD's efforts to control costs through its cost containment requirement, to identity additional opportunities for reducing costs, and to establish the charateristics of the program's beneficiaries.

The analysis conducted by GAO is based on a review of HUD records for 179 projects at 10 HUD field offices, visits to 47 of the projects, and data on 802 Section 202 projects obtained from HUD's Computer Underwriting and Processing System. The study was limited to projects primarily serving the elderly.

GAO's report, published in 1986, reveals that although cost containment efforts had been successful in lowering costs, cost containment was having some undesirable effects.

Analysis of construction cost data revealed that cost containment projects averaged 16 percent less than the average cost of units in projects built before cost containment. Section 202 loans ranged from 9 percent to 25 percent less per unit and GAO estimated that these reductions lowered project rents an average of 10 percent. GAO concluded that without cost containment, Section 202 projects for fiscal year 1985 would have cost an additional $100 million.

There were problems related to the cost containment efforts. Units were, on average, 11 percent smaller, included more efficiencies, which are less popular than one-bedroom apartments, and fewer amenities for the residents.

One of the most significant issues raised by the study relates to the use of fair market rents (FMR's) which HUD established for an area on the basis of rents tenants are willing to pay for housing. GAO found that FMR's for a particular area play an important role in the ability of the project sponsors to provide quality housing for the elderly. Project rents cannot exceed 120 percent of the FMR established by HUD for an area. The income from project rents is used to pay for a project's operating and maintenance expenses and to amortize project financing cost (principle and interest). Consequently, by controlling the rental income which can be collected, FMR's serve to limit the mortgage financing of loans, and, in turn, the projects' construction costs. This makes it difficult for Section 202 sponsors in areas with relatively low FMR's to provide housing consistent with higher FMR areas.

FMR's preclude the construction of some projects built in one area from being built in another because their cost would be too high. In some cases FMR's for efficiency units required project sponsors to reduce construction costs by amounts greater than that saved by building efficiencies instead of one-bedroom apartments. Another unfair scanario arises when projects in some States are exempted from real estate tax and can afford to use more of the project's rents for financing construction instead of taxes.

GAO discovered that although HUD requires projects with rents in excess of 100 percent of FMR's to comply fully with HUD's supplemental cost containment guidelines, projects with rents within 100 percent did not comply. In fact, no attempt was made to determine whether a project's features were excessive in some cases. Projects with rents over 110 percent were required to be reviewed by HUD headquarters for compliance.

The study also revealed inconsistent application of cost containment. GAO found that FMR's were difficult to establish for newly constructed units because comparable units are not available, and adjustments are subjective and prone to error and abuse. Past problems at HUD with establishing FMR's were reported by GAO in 1980 and included improper documentation and arithmetic errors.

HUD field offices were found to have waived the 25 percent efficiency requirement in some cases and 18 percent of the cost containment projects reviewed had no efficiency units. Furthermore, projects receiving waivers were not required to meet the HUD space requirements.

GAO found that program costs could be reduced further. They estimated that HUD could save an additional $19 million annually if the number of efficiencies reflected the projected single elderly population expected to live in the projects. Efficiencies are estimated to average $2,800 less to construct than one-bedroom units, and 80 percent of the tenants in the sample were single when they moved into their projects. Not all elderly are provided with the same amount of space, but all tenants pay the same rent (30 percent of income) regardless of the type of unit they occupy. Even though efficiencies are less expensive to construct, sponsors have little incentive to include more efficiencies than HUD requires (25 percent) in view of the effect that the lower FMR's for efficiencies can have on project construction cost and financing.

Critics of the HUD construction requirements for cutting costs say that they are so stringent that some of the new buildings are too poorly constructed to last the 40-year term of the mortgages. Therefore, amenities like meeting halls and hobby centers, which draw the elderly into a community, are being sacrificed. In conclusion, these initial findings strongly suggest that there are cost containment issues that must be resolved to provide the most elderly with suitable housing given the limited funds available for the Section 202 program.

(6) Rental Rehabilitation

In recent years, HUD has displayed a tendency to disassociate Section 8 vouchers from the rental rehabilitation program, which would appear to go against the original design of the program. Not only was the program enacted to ensure that the housing supply in urban areas was adequate and liveable, but also that those tenants displaced either physically (through the actual rehabilitation process) or economically (through higher rents) would be provided with other housing options. The Housing and Community Development Act states that those tenants physcially displaced must be provided with rental assistance. Those who are economically displaced may or may not receive assistance, which will be left to the discretion of their local public housing authority. Program funding for rental rehabilitation was $200 million in fiscal year 1987, and HUD allocated 10,000 vouchers to be used in conjunction with the program.

The 1987 act authorized an appropriation of $125 million for rental rehabilitation for fiscal year 1988, and an additional $75 million for vouchers. The 1987 continuing resolution appropriated $200 million for the program.

(7) Tax Reform

A large and important part of Federal housing assistance is provided through the tax system—more than $50 billion for fiscal year 1988, mostly for middle- and upper-income homeowners. The principal tax provisions encouraging home ownership are the mortgage interest and property tax deductions. The latter is probably more important to elderly owners since many have fully paid their mortgages. Under the Tax Reform Act of 1986, interest on mortgages in existence prior to August 16, 1986, on a first or second home remain fully deductible. Interest on mortgages incurred after that date, however, are deductible only to the extent that total loan amounts equal no more than the original purchase price of the owner's current home plus the costs of home improvements. An exception is made for home loans used for qualified educational or medical expenses. However, the sum of all such equity-secured loans cannot exceed the current market value of the home. The new rule means that those who have lived in their current home for many years and now have substantial equity may find the cost of future loans secured by this equity is higher because the interest may not be fully deductible. The same loan limits apply to an owner's second residence. Of particular importance to the elderly, the one-time exclusion that allows a homeowner aged 55 and older to sell his or her home and exclude up to $125,000 of capital gains from the Federal income tax was continued under the Tax Act of 1986.

A number of important tax incentives having to do with the provision of rental housing were reduced or eliminated under the new Tax Act. There is a less generous depreciation schedule, limitation on the amount of rental loss that can be deducted by an investor, and the end of preferential capital gains taxation.

To increase the supply of rental housing units available and affordable to low-income households, including the elderly, the 1986 Tax Act created a new low-income housing tax credit. From 1987 through 1989, investors will be able to apply for 10 years of tax credits for new construction, or the substantial rehabilitation or purchase of existing buildings, where a specified percentage of units are set aside for low-income renters for at least 15 years. Some housing analysts have estimated this new credit has the potential to add 140,000 new low-income rental units in each of the 3 program years. However, a 1987 report prepared for the National Council of State Housing Agencies says that probably less than 25 percent of the 1987 tax credit authority will be used. Problems with the program include the failure to enact technical corrections legislation, delays in receiving Federal tax program regulations from the IRS, the slow start-up of State programs due to the complexities and restrictions of the law, and concern that the size of the credit may be inadequate.

In addition, the Tax Act imposed new restrictions on tax-exempt bond financing used for multi-family housing. Instead of 20 percent of a building's units having to be set aside for families earning 50 percent or less of median area income, at least 40 percent of units must be reserved for those with 60 percent or less of median income. While most housing groups applaud the deeper targeting requirements believing this will mean more of the financing assistance will go to those who need help the most, some in Congress say that these and other changes have made it difficult to use tax-exempt bonds in areas that have particularly high housing costs, such as in New York City and parts of California. The Tax Act also lowers the amount of tax-exempt bonds that can be sold in 1987, and reduces this amount still further for 1988 and beyond.

The possibility that many federally subsidized housing units now occupied by low-income households could soon be legally withdrawn from the market by their owners or converted higher-priced rentals or to condominiums has housing groups very concerned. A number of legislative proposals to address this issue are likely in the near future. One bill expected to be introduced by Representatives Barney Frank and Charles Rangel in 1988 would offer tax incentives to current owners if they agreed to maintain the projects as subsidized housing for another 20 years or to sell them to other investors who would agree to keep them for low-income housing use.

Numerous technical amendments to the Tax Act have been introduced that supporters of the new low-income housing tax-credit say are critically needed if this major new housing program is to produce anywhere near the number of units expected of it. Many of these changes were included in bills passed by the House and Senate tax writing committees (H.R. 2636, S. 1350) in mid-1987, but were not passed by Congress in 1987.

(8) Farmer's Home Administration

Over the past several years, the administration has tried, with little success, to dismantle most of the Farmer's Home Administration housing programs. It contends that FmHA plays a minor role in providing housing assistance to rural areas and that the housing needs of rural communities will continue to be served by other sources. Opponents argue that the existing FmHA programs were not created in a vacuum, but were the result of congressional response to perceived needs, and that those needs continued to be unmet for many low-income rural residents. Housing vouchers, for example, will not enable low-income rural homeowners to improve their water and sewer systems.

The administration, in its fiscal year 1986 budget, proposed to shrink the FmHA role to its original one of providing credit to farmers. All FmHA housing programs would have been eliminated. The Congress rejected the administration's proposal and voted instead to fund the programs at a 30 percent reduction from the fiscal year 1985 level.

The fiscal year 1987 budget again proposed the termination of the rural housing programs of the FmHA. In addition, the administration proposed a rescission of $700 million in fiscal year 1986 funds. The $101 million in cuts directed by Gramm-Rudman-Hollings plus the proposed rescission would have resulted in a 55 percent reduction in the fiscal year 1986 funding level for rural housing. The Congress pased a supplemental appropriations bill (Public Law 99-349) which restored $706 million in deferred fiscal year 1986 funds. In addition, the Congress voted to continue the rural housing programs in fiscal year 1987 and funded them at the fiscal year 1986 level.

The administration's budget for fiscal year 1988 would have terminated all existing FmHA rural housing programs. The programs would have been replaced with a rural housing voucer program consisting of 20,000 vouchers and an additional 1,200 vouchers for tenants who become displaced because of prepayment of rental housing loans financed by FmHA. In addition, the Administration proposed to rescind 80 percent of fiscal year 1987 appropriated grant funds and to reduce fiscal year 1987 appropriated loan funds by 70 percent by requesting a negative supplemental appropriation.

The 1987 continuing resolution provides $1.23 billion for low-income, single-family loans (Section 502), and $544 million for rural rental housing loans (Section 515). The rural housing repair loans program (Section 504) is provied with $11.3 million, and farm labor housing loans (Section 514) are provided with $11.4 million.

The Housing and Community Development Act of 1987 authorizes FmHA programs for 2 years, with loan and guarantee authorizations in fiscal year 1988 at $1.775 billion and in fiscal year 1989 at $1.795 billion. It also, at the administration's request, authorized a 2-year FmHA rural voucher demonstation program in up to five States to provide up to 7,500 vouchers in each of fiscal years 1988 and 1989. This demonstration program requires participating States to complete an inventory of the local housing supply and to certify that there is an adequate supply of decent, safe, and sanitary low-income rental housing available for voucher holders in the State. However, the program is contingent on a specific appropriation to fund the units, and there was no appropriation for fiscal year 1988, nor is one expected for fiscal year 1989.

Another provision in the legislation concerns the prepayment or refinancing of a Section 514 or 515 loan. The provision would give the right of first refusal to nonprofit and public agencies, and would permit those agencies to use Section 515 loans to finance the transfer of ownership. Further, the definition of domestic farm labor (for purposes of determining eligibility for Section 514 and 516 loans) has been expanded to include retired or disabled farmworkers. Such persons are eligible to occupy assisted housing in places other than where they were employed as farmworkers if they wish to be closer to family members or to return to their home town.

(9) Home Equity Conversion

Developers hoping to find a lucrative market among the increasing numbers of elderly in the United States are learning that their competition is not with the retirement home, but in the single-family home. Economists estimate that there is $630 billion of equity tied up in the houses of people older than 65 and that, by

1990, that figure will reach $750 billion. Thus, attention has been paid in recent years to financial arrangements that would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion plans (HECP's) offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. HECP's also could provide funds to allow older persons to pay for needed support services, home maintenance, and other needs. Before HECP's the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

Homes are older Americans' most commonly held and most valuable assets. Three out of every four elderly persons own their homes and recent statistics indicate that 80 percent of these do not have a mortgage. Equally significant, a large portion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

There are two distinct types of conversion plans—debt and equity—on which a variety of models are based. Debt plans allow an older homeowner to borrow against home equity with no repayment of principal or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrower, a stream of monthly payouts for a given term, or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as reverse mortgages or reverse annuity mortgages.

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the loan is repaid to the State from the proceeds of the sale of the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays the taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the down payment can provide income beyond the land contract term. These plans are also referred to as sale/leasebacks.

The basic theoretical forms of HECP's have been established for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans have not been sufficiently attractive to borrowers.

The Housing and Community Development Act of 1987 contains a provision—developed by Senator John Heinz—to create a demonstration program of mortgage insurance for home equity conversion mortgages for the elderly. Under this demonstration program, the interest rate on the loans may be fixed or variable. However, the variable rate is capped at 5 points above the original rate and should only be provided on home equity conversion mortgages that provide either monthly disbursements that do not diminish for as long as the borrower owns the home as a principal residence or a line-of-credit in which interest on each disbursement accrues at a fixed rate for the life of the mortgage, but different disbursements may be subject at different rates.

The cost of home equity conversions involving shared appreciation of the property between mortgagor and mortgagee should be limited to protect borrowers against high effective interest rates (the combination of fixed interest plus shared appreciation. Insurance benefits on home equity conversion mortgages involving shared appreciation should only be paid to borrowers and only in cases of lender default. Such mortgages must provide: Monthly disbursements that do not diminish for as long as the borrower owns the home as a principal residence, loss of all interest and appreciation sharing as a penalty for defaulting lenders, full disclosure of potential "worst case" loan costs involving shared appreciation, and continuing deferral of the borrower's repayment obligation for as long as the borrower owns the home as a principal residence.

The mortgage must defer the homeowner's obligation to satisfy the loan obligation until the death of the homeowner, the sale of the home, or the occurrence of other events specified in regulations promulgated by HUD. The program allows the involuntary displacement of homeowners in "extraordinary" situations, which HUD must clearly delineate in regulations. These extraordinary circumstances would include the borrower contracting an illness requiring permanent institutionalization, the borrower permitting the property to fall into extreme and dangerous disrepair, or the borrower donating the property while retaining occupancy.

(10) Prepayment

Probably the most widely discussed issue concerning assisted housing programs is that of prepayment of Federal loans and mortgages on assisted projects. In the last few years, HUD has received numerous requests from borrowers of old Section 202 loans and from owners of other assisted projects with FHA-insured loans for permission to prepay their loans and mortgages. In assisted FHA-insured projects, many owners have a contractual right to prepay (without requiring permission) after 20 years.

The reasons for prepayment vary. The projects may be in a condition and/or location that permits profitable sale for condominium conversion or conversion to nonresidential use. In some instances (in the Section 202 projects) the borrowers argue that many projects are more than 20 years old and have suffered extensive deterioration as maintenance has been deferred. With many of these projects heavily in debt and unable to raise rents to support the cost of repairs, the project owners say that they have no way of rehabilitating the premises. Owners claim that if they were allowed to prepay their loans, the projects could be sold to profit-motivated owners who could afford private financing for needed repairs.

Other borrowers say that prepayment of loans should be permitted on projects no longer essential to the community. These are projects that were supplanted by newer developments. Borrowers believe that if they were permitted to repay the loans, their projects would be converted to other uses, still leaving adequate housing in the area for the elderly.

Estimates vary as to the likely number of prepayments that may occur in the assisted FHA-insured stock. The Reagan administration estimates that about 306,000 units will reach the 20 years of age between 1986 and 1996. HUD, taking market conditions into account, estimates that 154,000 of these are likely to prepay. In addition, an unknown number of the 850,000 project-based Section 8 assisted units may choose to "opt-out" of their contracts, or their contracts may expire within that same time period.

The General Accounting Office estimates that by 1995, the combination of expiring rent subsidies and potential mortgage prepayments could reduce the current inventory of privately owned low- and moderate-income rental housing by 200,000 to 900,000 units. According to the National Association of Home Builders, it would cost more than $130 billion to replace the existing stock of such housing. A number of private organizations are now studying this issue to obtain a better estimate of the number likely to be lost to the assisted stock, and the most appropriate way of dealing with the problems that may result.

Housing activists fear that a housing crisis is truly in the making. They note that this potential reduction comes at a time when Federal subsidies for low-income housing have been reduced 70 percent over the past 7 years, while tax reform has taken away much of the incentive to invest in low-income housing, and while HUD is not committed to building any new subsidized rental housing.

The Housing and Community Development Act of 1987 contains several provisions that address this issue. Essentially, the provisions establish that an owner of an eligible housing may prepay only in accordance with a plan of action approved by the Secretary of HUD. An owner wishing to prepay or initiate other changes in the status or terms of the mortgage must file a notice with the Secretary and any appropriate State or local government agency. Other changes are those related to an owner's acceptance of certain incentives in exchange for an agreement to retain the housing for low- and moderate-income use for the remaining term of the mortgage. These plans of action will differ markedly from project to project. For example, an owner seeking to prepay the mortgage and terminate the affordability restrictions would be expected to provide detailed information on the impact of such actions on the current tenants and the local supply of low-income housing.

If an owner demonstrates a willingness to keep the housing affordable to low- and moderate-income households, the Secretary is authorized to offer the owner a package of incentives. These incentives include an increase in the rate of return on equity, the provision of additional Section 8 assistance, an increase in rents under existing contracts, or the provision of a capital improvement loan.

The Secretary will take into account local market conditions and tenant population in formulating incentives. Wherever possible, State and local agencies will be expected to take a leading role in finding appropriate solutions for projects. According to the act, an array of Federal, State, and local incentives will be needed to solve the prepayment problem.

The Secretary must provide a written assessment of the plan within 60 days of receipt and final approval within 180 days of receipt. There will be two kinds of plans: Those that request permission to prepay a mortgage and those that request incentives to keep the housing affordable to low-income tenants. Therefore, there will also be two types of approval criteria. For the first type of plan, the Secretary must ensure that implementation of the plan will not create hardships for current tenants or materially affect the general supply of low-income housing in the area. For the second type of plan, the Secretary must ensure, among other criteria, that the housing will be maintained as low-income housing for the remaining term of the mortgage, that any rent increases for current tenants would be phased in over 3 years, and that vacant units will have rents affordable to low-income tenants.

Those who formulated this legislation noted that a number of private sector task forces (including those established by the National Housing Conference, the National Corporation for Housing Partnerships, and the Advisory Council of HUD Management Agents), as well as State and local organizations, have undertaken a review of the options and alternatives available to respond to the loss of low-income housing. In the interim, before the studies and recommendations of the task forces are completed, it is the intent of Congress that these provisions are to be emergency stop-gap measures to be used to avoid the irreplaceable loss of low-income housing and the displacement of tenants.

They note that an adequate supply of low-income housing has always depended on a strong long-term partnership between the public and private sectors that accommodates a fair return on investment. Reductions in the Federal housing budget and changes in tax benefits previously associated with low-income housing have increased incentives for private industry to withdraw from the production of low-income housing. The provisions within the Housing and Community Development Act are based on the premise that efforts to preserve low-income housing must be designed with the unique financial and market conditions of individual projects in mind.

(11) Bricks and Mortar Versus Supportive Services

During a period when the Federal commitment to provide housing is in question, some concerns have been raised about the need for additional supportive programs. The primary Federal focus on the "bricks and mortar" aspect of housing fails to address the supportive service needs of those being assisted. Further, this emphasis tends to discourage the development of other shelter alternatives that incorporate such services.

(a) Congregate Housing Services Program

Since 1971, public housing authorities have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. No subsidy was to be provided to cover the cost of meals and other services. To date, there has been little development of these congregate facilities. A study on long-term care released by the Development of Health and Human Services in 1981 cited a variety of reasons for this, including local housing agencies having had little experience in managing the necessary services, there has been little Federal encouragement and support, and there is no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local service agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

The Congregate Housing Services Program (CHSP) was set up to be a demonstration program, with $20 million to be spent over a 5-year period. HUD extends multi-year grants (3–5 years) to eligible public housing agencies and nonprofit Section 202 sponsors for meals and other supportive services for frail elderly and nonelderly handicapped residents. The program was designed to help the elderly remain in rented dwellings as they age, rather than be institutionalized. As of 1987, $30.3 million had been obligated to grantees. Sixty-one grantees are in operation, serving approximately 2,000 residents. Preliminary evaluation of the CHSP indicates that it serves those individuals most in need and is more cost effective than formal institutionalization.

The philosophy of Section 202 housing is to foster independent living. Section 202 projects were not intended to be either intermediary care facilities or standard apartment rental units. Instead they were meant to provide shelter plus services appropriate to the needs of the elderly and handicapped. Although they originally were designed to serve healthy elderly, survey results show that the majority of Section 202 tenants are aging in place and are now in need of more supportive-type service than when they entered the projects. Survey results reveal that the average age of a tenant in one of the older Section 202 projects is 78, while the average age of a tenant living in a project built under the new program is only 71. Results also indicate that, overall, 17 percent of these tenants are considered by project administrators to be frail.

Although an average of six on-site services are offered per Section 202 project, the types of services (such as personal care and housekeeping) that will enable the "aging in place" population to remain independent are offered on a very limited and fragmented basis.

There is no Section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs however they choose. In the future, Congress will need to develop uniform guidelines to ensure that Section 202 sponsors will provide supportive service to help their aging populations to remain in their dwellings as they age, rather than be institutionalized.

In 1984, 28 million people (11.8 percent of the population) were 65 years of age or older. Of these, 1.5 million were living in nursing homes. Since the disabilities of nursing home residents vary from old age to severe handicaps, many of these people may be candidates for congregate housing. While there is no way of precisely estimating the number of elderly persons who need or prefer to live in congregate facilities, groups such as the National Gerontological Association and the American Association of Retired Persons have estimated that a large number of people over 65 and not living in institutions or nursing homes would choose to relocate to congregate housing if possible. In addition, there are often reports of elderly occupants of nursing homes and other institutions who had no other choice of residence due to lack of alternatives adapted to different levels of independence, even though they did not require skilled nursing care.

In recent years, Congress has been appropriating funds for the maintenance of congregate housing projects already in existence. Congress appropriated $3.4 million in fiscal year 1987. The Housing and Community Development Act authorizes $10 million each year in fiscal years 1988 and 1989, and deletes the reference to congregate services as a demonstration program, making it a permanent program. The act states that a project is not required to provide a set number of meals, as long as the nutritional needs of the frail elderly are met. The 1987 continuing resolution appropriates $4.2 million for CHSP in fiscal year 1988. While the funds authorized and appropriated for CHSP do not represent a huge increase over previous years, they do represent a congressional commitment to the program that has endured despite repeated attempts from HUD and the administration to eliminate it.

Since funding for housing programs has been reduced in recent years, some States have established their own congregate housing programs in an effort to provide their elderly citizens with needed care without relying on Federal funds. A number of these State programs are described in a Congressional Research Service report issued in 1986. In the last few years, private developers have shown a growing interest in development of congregate housing. Congregate housing appears to be a viable alternative for housing the semi-independent elderly.

(b) Mandatory Meals

In 1987, HUD published final rules on mandatory meals programs in Section 202 units. Essentially, the rule authorizes mandatory meals programs already in existence, but will not approve any new programs in existing or future projects. In formulating these rules, HUD took into consideration a number of opposing arguments, and views them as a compromise between protecting residents' rights and independence as well as ensuring their nutrition, and protecting sponsors' housing-and-services ideal.

To put the issue in perspective, a 1985 GAO study found that only 512 of the 903 sponsors of Section 202 projects offer meals programs, and only 98 of those are mandatory. Seventy percent of residents participating in the mandatory programs report that they are satisfied with them, and 80 percent of all residents in mandatory programs would not leave the program if permitted. Only 17 percent of residents dislike the mandatory meal program. Twelve percent indicated neither like nor dislike.

Many advocates for the elderly object to this program. They believe that forcing a resident to participate in a meal program when he or she could and would prefer to prepare his or her own food appears to be an infringement of individual rights and contradicts the support for elderly independence to which Section 202 sponsors are dedicated. Those in support of the program cite the fact that the adequate nutrition of elderly residents is a primary concern of Section 202 sponsors. Many residents do not take the time, have the interest, or even remember to eat properly. Further more, as they age in place, residents increasingly are unable to prepare meals for themselves. Twice as many residents over 80 experience this difficulty, compared to those between 62 and 79.

Isolation is another problem of the elderly addressed by this program. Mandatory meals encourage residents to get out of bed, get dressed and leave the isolation of their rooms for the more social atmosphere of the dining room. Daily meals also help project sponsors conduct informal "resident checks" thus aiding in awareness of which residents are ailing or missing.

It is evident that there are benefits derived from meal programs, but there is some question about whether it is necessary to maintain the mandatory status of existing programs in order to offer a meal program. Ninety-two percent of mandatory meal managers believe that they could not continue to provide meals if forced to make the transition to a voluntary program. At the very least, they believe that meal prices would increase because the program receives no Federal money and runs with a very small profit margin.

Currently operating mandatory programs were established in good faith with HUD's permission, and some argue that forcing them to make what is predicted to be an unsuccessful transition to voluntary status is unfair. The General Accounting Office advised against prohibiting these programs, acknowledging the risk of eliminating meals programs entirely.

(12) Prognosis

In 1987 as in previous years, Congress opposed the Reagan administration's housing policies. The legislators rejected White House proposals to eliminate most forms of housing assistance and fought drastic reductions in public housing operating subsidies. However, in this time of limited funding, new construction is being discouraged, although it will continue to be funded under the Section 202 program for the elderly and handicapped. In other programs, rehabilitation and use of existing housing will be the norm.

Despite congressional efforts to the contrary, Federal housing assistance still meets only a small fraction of the housing needs of the low-income elderly. Low-income housing has taken deeper cuts than any other program providing aid to low-income people, and these cuts have come in the face of ever-increasing need.

While the role of the Federal Government still remains significant because of its prior subsidy programs, it is clear that the role is diminishing and will be limited in the future. State and local commitments to public housing are becoming increasingly important. However, they vary widely, and many States do not have adequate resources to support programs. Although reductions in direct Federal spending on housing programs can be expected to result in some amount of replacement spending by the private sector, the mix and type certainly will be less oriented toward benefiting low- and moderate-income households and neighborhoods.

While the Housing and Community Development Act of 1987 does not offer many long-term solutions to the housing problems facing Americans of all ages, the legislation is nonetheless a victory for housing advocates. The home equity conversion demonstration program should help to stimulate the interest in home equity conversion transactions. This concept has become very attractive to many of the large number of older Americans who have substantial equity in their homes yet are faced with meeting the high costs while living on fixed incomes. The act also begins to address the crucial issue of prepayment of mortgages for low-income housing.

If we are to meet the goal of a decent home for every American family and individual, Congress must not acquiesce in proposals to terminate housing programs and congregate services for the elderly. It must also resist any further major reductions in operating subsidies for low-rent public housing.

(B) INNOVATIVE HOUSING ARRANGEMENTS

The single-family house, increasingly void of children, has come to represent the discrepancy between the needs of a burgeoning population of elderly homeowners and the lack of housing alternatives. Recently, several types of solutions to the problems of those elderly trapped in houses too large for their needs and too costly to maintain have surfaced. These include retirement communities, board and care homes, life care communities, shared housing and ECHO, or "granny flat" arrangements.

(1) Retirement Communities and Limited Care Facilities

The Federal Government is supporting several congregate care housing demonstration projects. In addition, a few States are establishing congregate housing programs. There is, however, little direct public assistance to fill the gap between totally independent living arrangements and health care-oriented retirement communities. Accordingly, the private sector has stepped in to provide various options. These range from low-cost elderly housing, board and care facilities to relatively expensive life care and retirement communities. Retirement communities differ in the range of housing, social, and health care services they provide. Most provide independent housing, congregate meals, and social and recreation activities. Some also have 24-hour nurse service and wellness clinics, and others provide a continuum of care that includes independent living units, personal care, and nursing home care services.

In the past, the Senate Special Committee on Aging has made a point of scrutinizing the Nation's estimated 300,000 board and care homes serving low-income older persons. The Aging Committee, in 1983, also conducted an investigative hearing on the benefits and shortcomings of the life-care industry.

(2) Board and Care Homes

Most of the more than 1 million residents of boarding homes and foster, adult, or domiciliary care facilities receive some form of public assistance. Managers of the 300,000 such homes often have been criticized for inadequate safety and security measures, poor care, abuse of the residents, and even financial fraud.

In 1976, after a number of fires in board and care homes, Congress added section 1616(e), known as the Keys amendment, to the Social Security Act. This provision requires that for group living arrangements in which a significant number of Supplemental Security Income (SSI) recipients reside, States must establish and enforce standards that govern such matters as admission policies, safety, sanitation, and protection of civil rights. In making this change, Congress sought to prevent the SSI program from becoming a source of funds for substandard institutions.

The Keys amendment does not mandate Federal regulation or licensure of board and care homes. There is only one enforcement sanction available to punish provision violators—the power to reduce the SSI checks of residents of homes not in compliance with State regulations. This include States with no regulations at all. Although all States now have health and safety provisions in law, Federal efforts to enforce board and care home standards have been hampered by lack of direct Federal funding of these facilities (SSI benefits are paid directly to board and care home residents or their representative payee, not the facility). This contrasts with nursing homes, where Federal Medicaid and Medicare Programs pay the provider of care directly. Consequently, the Federal Government has been able to achieve stronger regulatory requirements for skilled nursing and intermediate care facilities.

(3) Life-Care Communities

Life-care communities, also called continuing care communities, typically provide housing, personal care, and nursing home care, and a range of social and recreation services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of a resident's life. In its study on life care, the Pension Research Council of the University of Pennsylvania developed a definition of life-care communities. It includes providing specified health care and nursing home care services at less than the full cost of such care, and as the need arises.

Estimates on the number of life-care communities range from 300 to 600, depending on the definition used. About 300 of these facilities serve at least 90,000 residents. According to The American Association of Retired Persons, the number of life-care communities doubled in the past 10 years and is expected to more than double in this decade. While most life-care communities are operated by private, nonprofit organizations and some religious organizations, there has been an increasing interest on the part of corporations in developing such facilities.

Some analysts view this concept as a form of long-term care insurance. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more such services. Entrance fees are usually based on actuarial and economic assumptions, such as life expectancy rates and resident turnover rates, which is also similar to insurance pricing policies.

Entrance fees range among life-care communities from approximately $40,000 to more than $150,000, with monthly fees ranging from $500 to $2,000. This wide range results from such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. Life-care communities do not cover acute health care needs such as doctor visits and hospitalization, and some may require residents to share in the cost of the health or long-term care services they receive from the community. Studies have shown that the average age of persons entering life-care communities is 75. In independent living units, personal care units, and nursing home units the average ages are 80, 84, and 85, respectively.

Problems have been discovered in some communities, such as those using lifespan and health projections that are not actuarially sound, as well as incorrect revenue and cost projections. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned, even on a pro-rated basis. Recently, there has been a growth in the number of private nonprofit corporations which sponsor life-care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profit-making goals of the developer may conflict with the financial stability of the nonprofit corporation. For example, to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

While most life-care communities are managed effectively, some have faced financial and other problems. A growing phenomenon, life care is just beginning to be understood and regulated. Although California, in 1969, was the first State to regulate life care, only 13 States today regulate the operation of life-care communities. These States are: Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Michigan, Minnesota, Missouri, Oregon, Pennsylvania, and Virginia. New York, which bans prepaid nursing home care, effectively prohibits life-care arrangements. There is little uniformity in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few, if any, of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures and non-arms length transactions to enhance his personal wealth at the expense of the life-care residents.

The University of Pennsylvania's Wharton School of Business study suggested that States, when regulating life care, should address such issues as facility certification and accreditation, management of escrow accounts, maintenance of reserve funds, required financial disclosures, strengthening pre-construction requirements for bond holders, and the development of method to be used to test the ongoing financial viability of the community.

Problems in some life care communities raised concerns by many in Congress that participants be allowed to recoup entrance fees under certain circumstances. The Internal Revenue Code, however, treated refundable entrance fees as "loans" to the life care communities and imputed interest on the downpayment as income received by the elderly resident. This was viewed as a hardship to life care community residents, and in 1985 Congress enacted a proposal by Senator Heinz which exempted the first $90,000 of an entry fee from the imputed interest rules as part of Public Law 99-121. The House version of the 1987 reconciliation bill, H.R. 3545, contained a provision to repeal the exemption and reinstate the imputed tax treatment on the entire amount of a refundable entry fee. This proposal was rejected by the conference committee and was not contained in the bill as passed (Public Law 100-202).

Supporters of life care contend that there are a number of benefits associated with this concept. For example, the pooling of resources and risks may help to reduce the uncertainties of future costs of care, and there are greater opportunities for residents to maintain their health as health care and other services are provided on a regular basis. Others believe that while life care is an option for some elderly, it is unlikely that many with low and moderate incomes would be able to afford it. Further, many older person are reluctant to move from their homes and into a life-care community.

To address some of these concerns, researchers at Brandeis University are developing a finance and delivery model.[2] The model provides most of the same benefits to the elderly as a life-care community while enabling participants to remain in their homes. Services provided under this model would include skilled and intermediate nursing, personal care, home health and homemaker services, and respite and day care. The proposed costs of the model include a one-time entry fee of about $5,000 to $10,000, and monthly fees between $80 and $150, depending on local service networks and benefits offered.

(4) Shared Housing

Shared housing can be best defined as a facility housing at least two unrelated persons where at least one is over 60 years of age, and in which common living spaces are shared. It is a concept which targets single and multi-family homes and adapts them for elderly housing. Shared housing can be agency-sponsored, where 4 to 10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually three or four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

According to census statistics, some 670,000 people over 65 (excluding those who are institutionalized or in nursing homes) share housing with nonrelatives; a 35-percent jump over a decade ago. In a recent AARP poll of a sampling of its 23 million members on the subject of shared housing, 15 percent said they would consider sharing living quarters with someone outside their family.

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[2] Tell, E., Batten, H., Cohen, M., and Larson, M. (1986). *The Market Potential for Long-term Care Finance and Delivery Options: Results of a Telephone Survey,* unpublished manuscript, Health Policy Center, Heller Graduate School, Brandeis University.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. Dennis Day Lower, a director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost effective when compared to new construction. He has noted that per unit capital costs could be 50–60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced supplemental security income and food stamp payments to participants. Congress has recognized and begun to act on the need to overcome these impediments. They included a provision in the Housing Act of 1983 for Section 8 rental assistance to be used with shared housing. Under this provision, the existing and moderate rehabilitation programs of Section 8 can be used to aid elderly families in shared housing. HUD will issue minimum habitability standards to insure decent, safe, and sanitary housing as an eligibility activity under the Community Development Block Grant Program.

Several shared housing projects are in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities. It helps match people looking for an affordable place to live with those who have space in their homes and are looking for someone to aid with their housing expenses. Some of the people helped by Operation Match are single working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

(5) Accessory Apartments and Granny Flats

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighborhood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Accessory apartments are another form of shared housing, except that each unit has its own kitchen, so this form of housing undergoes the same zoning restrictions and impediments already discussed in the section of this report concerning shared housing. According to one expert, about 40 percent of the single family housing stock in the country is now zoned to permit accessory apartments. According to this expert, once zoning is changed, there are a large number of applications to legalize existing accessory apartments, but very few applications for new ones. The reason is that the homeowners must deal with local government zoning and building regulations, as well as with contractors, banks, and tenants. Unfortunately, the process is intimidating for many people and it is difficult to find reliable advice. The expert suggests a basic partnership between real estate agents and remodelers to market accessory apartments.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO" flat, first constructed in Australia and recently introduced in this country. "Granny flats" were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as "ECHO units," an acronym for elder cottage housing opportunity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

(6) Prognosis

Innovative housing programs will become more and more essential in providing basic housing and support services for our Nation's elderly, handicapped, and poor. But Congress, with its full agenda of issues, is unlikely to focus much attention in 1988 on innovative housing for the elderly. Hearings will be in order, but action on expanding shared housing options and further life-care facility policy is not a high priority. It is very unlikely that legislation on these issues will reach the President's desk for signature in 1988.

In addition, the life-care industry is expected to grow by leaps and bounds over the next several years, mainly appealing to the upper-middle income groups. There is consideration being given to life-care facilities for lower income Americans, primarily those that have been able to purchase a home during their lifetime. These efforts will be slow in evolving, however, and will be undertaken primarily by nonprofit life-care interests. The for-profit life-care interests will continue to expand during 1988.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence becomes a larger burden than many elderly can afford. The need for quality board and care facilities, accessory apartments, and granny flats will grow with the increase in the number of older Americans, but the role of the Federal Government will not be significant in 1988.

Chapter 11

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

During the 14 years since OPEC first embargoed oil sales to the United States, energy use and conservation have become major domestic policy issues, particularly for those who monitor the economic security of the elderly and poor.

Several Federal programs have been instituted to ease the energy cost burden for needy individuals. The most significant of these are the Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's Weatherization Assistance Program. Over the years, these programs have been modified in response to both growing need and apparent deficiencies in design and implementation, and have come under increasing scrutiny in the effort to reduce Federal budget deficits.

Although these programs have played an important role in helping millions of America's poor pay for their basic energy needs and weatherize their homes, there is a widening gap between existing Federal resources and the needs of the population these programs were intended to serve.

In each of fiscal years 1986 and 1987, LIHEAP provided heating assistance to an estimated 6.7 million low-income American households, down from 6.8 million in fiscal year 1985. These households represent about 29 percent of all households with incomes under the Federal maximum standard for the program (150 percent of poverty or 60 percent of State median income); or about 37 percent of all households with incomes under the stricter income standards adopted by most States, which range from 110 percent of poverty to the Federal maximum standard. About 38 percent of low-income households receiving heating assistance contain at least one elderly member, about the same proportion of all low-income households that have an elderly member.

The Reagan administration has attempted in recent years to cut substantially LIHEAP and to eliminate the DOE Weatherization Program. Over 3 years, Congress has cut appropriations for LIHEAP by 27 percent with a 16 percent cut for fiscal year 1988. This could mean that either every recipient household would lose almost $46 a year in heating assistance or more than 1 million households would lose LIHEAP benefits in 1988.

Congress continued to view these programs as the Federal Government's major effort to assist low-income households with their energy costs. However, the congressional perception prevailed that the States had substantial oil price overcharge funds available to use for funding LIHEAP, the States continued to transfer LIHEAP funds to other block grant programs and some thought that home energy prices had declined. But, home heating prices actually increased in 1987 and are projected to rise again for the 1988 home heating season. The programs have also twice been reduced under the Gramm-Rudman-Hollings Act, in 1986 and 1987.

A. BACKGROUND

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in the household budgets of Americans. The proportion of income required to purchase essential energy supplies rose dramatically and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirement, the pressure for change in consumption patterns and the erosion of real spending power due to energy inflation over the past 14 years has been unrelenting. The rising cost of energy has had a greater effect on the elderly and those with low incomes who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel.

According to a recent study by the Northeast Midwest Institute, fuel oil prices increased 428 percent from 1973 to 1985, while natural gas prices increased 371 percent and electricity 208 percent in the same period. During the same time, the Federal poverty level for a family of four increased only 142 percent.

The rise in energy costs in relation to income has been the impetus behind congressional enactment of both the Low-Income Energy Assistance Program and the Weatherization Assistance Program. Between 1972 and 1979, electricity costs rose 84 percent, natural gas prices increased 150 percent, and fuel oil costs rose 258 percent. These figures were well above the overall increase of 74 percent in the consumer price index for the same period.

According to the Department of Energy's Residential Energy Consumption Survey (RECS) for fiscal year 1986, LIHEAP households spent $992 or 15 percent of their incomes on residential energy as compared to $1,119 or 4 percent of total income for households of all income levels. All low-income households (annual incomes under the greater of 150 percent of the poverty line or 60 percent of the State's median income) spent $1,006, or 13 percent of their income, on their residential energy needs.

Analysis of the 1982–83 and 1984–85 RECS indicate that LIHEAP households consistently spent 8–10 percent more on home heating than the average of other low-income households. This may be attributed to the fact that more LIHEAP households in the survey are located in colder States and also are likely to contain more elderly members, more young children, and more households headed by females than the average low-income sample.

According to earlier RECS, beginning in 1979 and continuing for the next 2 years, the average household paid $100 more each year for household energy. In 1982, however, the increase slowed significantly. As pointed out by the Department of Energy, this slowdown in the rate of increase occurred because the increase in prices nearly was offset by the decrease in consumption. Overall, from

1981 to 1982, prices rose 14 percent while consumption dropped 10 percent.

In the early 1980's, fuel costs rose dramatically. Between December 1980 and December 1985, household fuel costs rose 32.6 percent. The trend slowed in 1985 as the average price of heating fuels increased only 0.7 percent between December 1984 and December 1985.

The U.S. Bureau of Labor Statistics reports that the consumer price index for household fuels actually declined 9.4 percent from December 1985 to December 1986. This figure reflects a 33.4 percent decrease in the cost of fuel oil, a 1.5 percent decrease in the cost of electricity, and a 5.8 percent decrease in the cost of natural gas.

However, from November 1986 to November 1987, the price index for household fuels increased again by 1.9 percent with fuel oils taking the biggest leap at 20.2 percent. Electricity prices increased 1.8 percent and the cost of natural gas declined by 2.8 percent. Using October 1987 data, the Department of Energy is projecting all residential fuel costs to increase for 1988—fuel oil by 7 percent, electricity by 3.5 percent, and natural gas by 2 percent. Only about 12–15 percent of low-income households use fuel oil for heating. Most use natural gas as their primary heating source.

The Department of Energy has estimated that energy consumption is higher for households with larger incomes. There is a large difference in average energy consumption and expenditures among households with different incomes. The highest income households use about 70 percent more energy than the lowest income groups. It was noted that their living quarters are about twice the size of the lowest income group and they usually have more appliances. From 1978 to 1980, there was a trend toward parity, with high-income households lowering their energy consumption more than low-income households did. The data for 1981, however, show a slight reversal of this trend. Households earning less than $5,000 reduced their consumption by an estimated 11 million Btu's, while households with incomes over $24,000 did not show a continued drop.

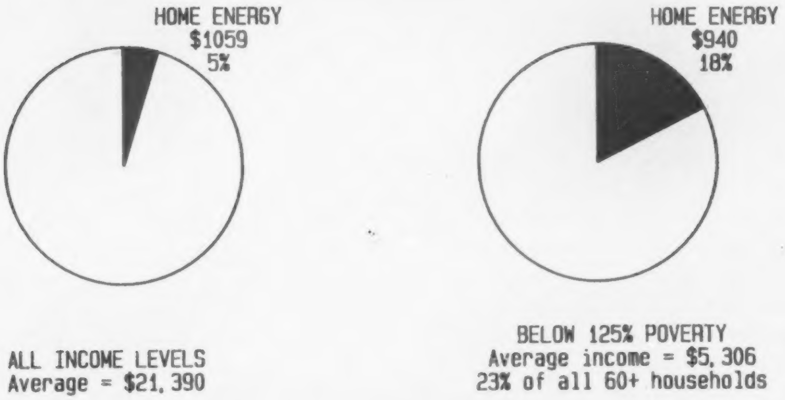
Rising energy prices affect all income groups, so that energy expenditures increased across-the-board from 1978 to 1981. Average expenditures for households in the highest income group ($1,333) were almost 75 percent more than those of the lowest income group ($766). In contrast, however, expenditures increased much more for the lower income group than for the higher.

During this 4-year period, beginning in 1978, expenditures for the lowest income group increased 47 percent, in nominal dollars, while expenditures for the higher income group increased 24 percent. Additionally, expenditures as a percentage of income are much higher for lower income groups. Low-income households typically spent about 20 percent of their income on energy, while high income households spent 3–4 percent of their income on energy. Among poor households, the burden of energy expenditures is highest in the Northeast and North-Central portions of the country. For example, in the Northeast, poor households (those below 100 percent of the poverty level) paid 29 percent of their income for household energy.

According to a recent study by the Villers Advocacy Associates and the National Council of Senior Citizens, elderly households with incomes below 125 percent of poverty spent almost 18 percent of their income on home energy, while home energy costs for elderly households of all income levels consumed only about 5 percent of their total income. In 1986 dollars, the study indicated that the average income of the elderly household below 125 percent of poverty was $5,306, of which an average of $940 was spent on home energy. The average income for all elderly households of all income levels was $21,390, of which $1,059 was spent on home energy. The following chart illustrates household spending of both elderly income groups.

CHART 1

HOME ENERGY COSTS AS A PERCENT OF HOUSEHOLD BUDGETS
(In 1986 Dollars)



Source: Villers Advocacy Associates and
National Council of Senior Citizens

The high cost of energy is a special problem for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, DC, has reported that experts estimate that hypothermia may be the cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many preexisting conditions and diseases in older adults, such as arthritis. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia.

1. The Low-Income Home Energy Assistance Program

The precursors of the current Low-Income Home Energy Assistance Program (LIHEAP) were a series of short term crisis intervention programs in the 1970's that were administered by the Community Service Administration (CSA) and limited to a $200 million annual appropriation. Between the winters of 1979 and 1980, the price of home heating oil doubled and Congress expanded aid sharply by creating a three-part energy assistance program at an appropriation level of $1.6 billion: $400 million to the CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services (DHHS) for one-time payments to recipients of Supplemental Security Income [SSI]; and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation and $1.85 billion was appropriated for the program that year. The current LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981) as amended by the Human Services Reauthorization Acts of 1984 and 1986. Appropriations for fiscal year 1988 of $1.5 billion have been cut sharply from the $2.1 billion appropriated for fiscal years 1985 and 1986 and the $1.825 billion for fiscal year 1987.

Under LIHEAP, block grants are made to the 50 States, the District of Columbia, approximately 121 Indian tribes and tribal organizations and 6 U.S. territories, allocated by formulas based largely on home energy expenditures by low-income households. Financial assistance is provided to eligible households, usually directly or through vendors, for home heating and cooling costs, energy-related crisis intervention aid, and low-cost weatherization. Some States also make payments in other ways such as through vouchers or direct payments to landlords.

States also are allowed some flexibility in the use of their grants—up to 10 percent may be tranferred into other block grant programs, up to 15 percent may be used for weatherization programs, and up to 15 percent may be carried over to the next fiscal year. No more than 10 percent of the grant may be used for administrative costs.

States may establish their own benefit structures and eligibility rules within broad Federal guidelines. Eligibility may be granted to households receiving other forms of public assistance such as Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), food stamps, certain need-tested veterans' and survivors' payments, or those households with incomes less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Lower income eligibility requirements may be set by States and other jurisidictions, but not below 110 percent of the Federal poverty level.

Other Federal requirements include: Structuring benefits so households with the lowest income and highest energy costs get higher benefits, equal treatment for renters and homeowners, outreach programs to inform those potentially eligible about the program, and equitable treatment between those who are income eligible and those who are categorically eligible.

According to DHHS, States provided heating assistance to more than 6.3 million households in fiscal year 1986. About 1.1 million households received energy crisis assistance, more often for heating than cooling. Based on previous estimates, DHHS estimates that about two-thirds of the households receiving winter crisis assistance also receive regular heating assistance. This would make the unduplicated number of households receiving assistance with heating costs to be about 6.7 million. This compares to the 6.8 million households assisted in fiscal year 1985. Preliminary estimates from a summer telephone survey of the States indicate about the same number of households received heating assistance in fiscal year 1987 as in 1986. DHHS also reported that 535,553 households received assistance for cooling costs in fiscal year 1986 and that more than 191,300 households received low-cost weatherization or other energy related home repairs.

According to the DHHS report to Congress for fiscal year 1986, the average LIHEAP benefit for heating assistance was about $231. This offset about 57 percent of the average fiscal year 1986 heating costs for recipients. Average fiscal year 1986 space heating costs for all households were about $412, while average space heating costs for low-income households were about $396, or about 3.9 percent lower than the average for all households. Average space heating costs for LIHEAP recipient households were about $406. On average, according to DHHS, households receiving LIHEAP benefits have higher heating costs and lower income than low-income nonrecipient households. Average heating costs for all households in fiscal year 1986 were 4.4 percent lower than in fiscal year 1985 because the winter was slightly milder and residential fuel prices dropped.

There remains a tremendous gap between the number of households actually receiving LIHEAP benefits and those that are eligible. Excluding individuals who may be categorically eligible for benefits (households where at least one individual is receiving food stamps, Aid to Families with Dependent Children, certain Veteran's benefits, or Supplemental Security Income), the Congressional Research Service estimates that 23.4 million households meet the income eligibility requirements for LIHEAP benefits. This estimate is based on the March 1984 Current Population Survey.

Unfortunately, DHHS cannot estimate precisely the number of households eligible for LIHEAP. Typically, States operate LIHEAP for only part of the year and no data source provides seasonal national information on income and participation in other programs which provide categorical eligibility for LIHEAP. Further, States' procedures for determining eligibility may annualize 1 or more month's income to test against the income standard the State has adopted. Thus, households may be eligible for LIHEAP even though their actual annual income is above the income maximum set in law.

With these qualifications, DHHS estimates that, according to the March 1986 Current Population Survey, as estimated 23.5 million households had incomes under the Federal maximum standard and an estimated 18 million households had incomes under the more strigent income eligibility standards of many of the States.

Poverty also has increased dramatically, from 24.5 million people living below the poverty threshold in 1978 to 33.1 million in 1985. According to a 1987 report on the energy needs of the poor by the Northeast Midwest Institute, the estimated number of households eligible for LIHEAP assistance increased from 12.6 million in 1980 to 23.4 million in 1985. Part of that increase is due to the change in Federal eligibility standards from 125 percent of Federal poverty levels to 150 percent.

2. THE DEPARTMENT OF ENERGY WEATHERIZATION ASSISTANCE PROGRAM

The Department of Energy's (DOE) Weatherization Assistance Program has been authorized under the Energy Conservation and Production Act of 1976, as amended. It is designed to reduce heating and cooling costs in homes of low-income households. Although it has not been reauthorized since its authority expired at the end of fiscal year 1985, Congress has continued appropriations for the program. Allocations for fiscal year 1988 are $161 million under the continuing resolution passed by Congress on December 22, 1987 (Public Law 100-202).

The program actually began under the Emergency Energy Services Conservation Program enacted by Congress in 1975 to provide relief to needy households by increasing the energy efficiency through insulation and repairs. By 1985, it had developed into a $191 million weatherization program. But since then, appropriations have dropped and the administration has been attempting to phase it out.

Through the program, funds are made available to States, which in turn allocate dollars to nonprofit agencies for purchasing and installing relatively low cost materials such as insulation, storm windows, and doors. Federal law allows a maximum average expenditure of $1,600 per household. To be eligible for assistance, household income must be at or below 125 percent of the Federal poverty level. States, however, may raise their income eligibility criterion to 150 percent of the poverty level to conform to the LIHEAP income ceiling. They may not, however, set it below 125 percent of the poverty level. Also eligible for assistance are households with persons receiving AFDC, SSI, or local cash assistance payments. Priority for assistance is given to households with an elderly individual (age 60 and older) or a handicapped person. The program has served more than 3.9 million homes from the program's inception through October 1987. In 887,578 of these homes, at least one resident was 60 or older. In fiscal year 1986, 153,564 homes were weatherized and 107,045 were done in fiscal year 1987.

The goals of the program include:

—Improved energy efficiency in the homes of participants,

—Reduced fuel bills for participants,

—Reduced national energy consumption, and

—Increased employment opportunities due to installing and manufacturing low-cost weatherization materials.

A DOE-sponsored evaluation of the Weatherization Assistance Program published in 1984 (based on 1981 data) showed that: [1]

> The program reaches elderly persons in accord with its statutory priority requirement.

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[1] U.S. Department of Energy. Energy Information Administration. Office of Energy and End Use. Weatherization Program Evaluation. SR-EEUD-84-1. Aug. 20, 1984. Executive Summary and pp. 1-2, 18-19.

> The program saves, on the average, about 13 percent of a home's heating energy. The study found that 50 percent of the weatherized homes surveyed had an energy savings of 10 percent or more; 23 percent had a savings of 20 percent or more; and 23 percent used more energy the year after weatherization.
>
> Energy savings relate to the type and cost of weatherization assistance materials. Homes receiving the most extensive weatherization services (insulation plus storm windows or doors) saved more than twice as much energy as weatherized homes that were not insulated. Insulation was a key measure for producing energy savings.
>
> Energy savings derived from a particular energy improvement, however, can be determined precisely only by measuring energy consumption under identical circumstances before and after the improvement is made. This condition is impossible to meet because conditions are always changing. For example, thermostat settings and energy use in a home changes from year to year.
>
> More of the homes weatherized are in colder weather zones and fewer are in temperate and warm weather zones.

As a result of these findings, DOE has begun to examine those elements of occupant behavior that most strongly contribute to differences in energy savings as well as the combination of weatherization materials that optimizes energy savings.

Beginning in calendar year 1987, DOE is authorized to establish a "performance fund" from which dollars will be awarded to States meeting its criteria for the best weatherization programs. Up to 15 percent of the amount appropriated each year for the DOE program would be used for the fund. The award criteria depends on the percentage of eligible dwelling units within a State that have been weatherized, energy savings resulting from weatherization activities, and the State's actual achievement of its weatherization assistance program goals.[2] However, the program will not become operational unless $205 million or more in annual appropriations is available.

B. ISSUES

1. Evaluating Energy Assistance and Savings

Of primary concern to the Special Committee on Aging is the effectiveness of energy assistance programs in serving older presons. Both LIHEAP and the Weatherization Assistance Program give priority to the elderly and handicapped citizens in assuring that these households are aware that help is available, and to minimize the danger of unnecessary shutoff of utility services. Specific data on the number of older beneficiaries continues to be unavailable. Changes to the law relaxed many of the reporting requirements, and, as a result, many States no longer maintain age-specific data. According to DHHS, about 38 percent of households receiving assistance with heating costs had an elderly member, about the same proportion of elderly among all eligible households. Thus, households containing elderly members are served roughly in proportion to their representation in the total low-income population.

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[2] Federal Register. Part V. Department of Energy. December 5, 1985. P. 49912.

Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be utilized as information and outreach bases for the programs. Discussions with area agencies on aging and senior center staff indicate that increased effort has been made in recent years to identify eligible elderly persons for energy assistance, and to provide the elderly population in general with information about the risks of hypothermia.

A 1986 GAO study of 13 diverse States accounting for 46 percent of the fiscal year 1985 LIHEAP appropriation and 49 percent of the Nation's low-income households, cited that all of these States reported using local organizations and aging agencies for outreach to the elderly and eligible households.

The debate over the effectiveness of LIHEAP and the DOE Weatherization Assistance program continues. Many argue that the programs have been well directed and effective for the neediest, yet conclusive data is not available.

According to a 1986 report prepared by the Economic Opportunity Research Institute for the National Association of State Community Services Programs, frail or disabled elderly people, the very poor, and households with a history of energy shutoffs are in greater need than many households that receive energy aid. It was estimated that about 2.8 million such households, with average incomes of $2,196, are not served. Households that receive aid under LIHEAP on average have higher incomes and lower energy costs than eligible households not receiving the aid. The report stated that meeting the needs of those not currently served under LIHEAP requires more money. Using 1984 average benefits, achieving a 55 percent participation rate would require a 23 percent increase in LIHEAP funding. A much higher increase would be necessary now because of recent budget cuts.

According to the DHHS report for fiscal year 1986, low-income households expend a greater proportion of their income for space heating than do other households. The percentage of income for heating is greater still for LIHEAP recipient households. The average annual income of LIHEAP recipient households is more than 15 percent less than the average annual income of other low-income households. Nationally, fiscal year 1986 heating costs represented about 5.1 percent of the average income of low-income households and 6.2 percent of income for LIHEAP recipient households, compared to about 1.4 percent of income for the average U.S. household.

LIHEAP, however, has its critics, who generally take one of two positions. One position argues that the public welfare system, excluding LIHEAP, already is either sufficient or too generous. Another position is that assistance is needed, but not in the form provided by LIHEAP.

Those who oppose specific energy aid for low-income individuals contend that, when combined with other welfare benefits, the LIHEAP increases work disincentives, unnecessarily increases the

Federal deficit, and makes the cumulative benefits under all welfare programs too generous, especially since LIHEAP benefits are not counted as income for determining eligibility and benefit levels under other means-tested assistance programs. It is also argued that LIHEAP was intended to be only a temporary emergency measure, designed to help households cope with the energy price shocks of the 1970's, and should not become part of the permanent public welfare system.

Others may favor energy-related aid for those with low incomes, but maintain that assistance would be provided more efficiently through the more established means-tested programs such as AFDC, SSI, or food stamps. However, this would exclude the currently estimated 30 percent of LIHEAP recipients who are nonwelfare poor, such as the elderly and working poor.

Others argue that LIHEAP, by increasing household income available for energy, discourages energy conservation. The twin goals of helping low-income households meet high energy costs and encouraging energy conservation would be better achieved, some assert, through home weatherization or renewable energy home improvements.

Various studies have attempted to quantify energy savings from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing conditions of dwelling units and varying climatic conditions and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in homes that have been weatherized. Experts in this area have noted that most studies do not use control groups where fuel costs in homes weatherized are compared with fuel costs in homes not weatherized. Lacking a control group, it is difficult to accurately predict whether changes in energy consumption are due entirely to weatherization assistance or to changes in fuel prices, conservation programs, appeals from political leaders, or a combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States that administer the DOE program. While DOE has claimed a 20–25 percent annual energy savings in homes weatherized through its program, GAO reports that this statistic has questionable reliability because of DOE's sampling and data problems.[3]

A study conducted in the State of Minnesota of its weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded that the DOE program was successful in reducing energy consumption by an average of 13 percent. The study also concluded that the cost of weatherization is likely to be repaid within 3½ years through lower fuel bills.[4]

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[3] U.S. Government Accounting Office. Uncertain Quality, Energy, Savings, and Future Production Hamper the Weatherization Program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. October 26, 1982. Washington, 1982. pp. 18–20.

Although this evaluation initially showed promise for a careful examination of energy savings, the GAO reported that the study was too geographically limited to reveal savings on a nationwide basis. In the final analysis, GAO has concluded that there is no nationwide study on cost savings that incorporates standardized statistical methods in a way to assure maximum reliability. However, the evaluation discussed earlier in this chapter under the DOE Weatherization Assistance Program description was conducted after GAO's analysis, and provides evidence that the program is working. A number of States have also conducted studies since that time and many show energy savings in the 14-25 percent range.

2. Block Grant Versus Categorical Funding

Another issue concerns funding Federal weatherization programs through block grants versus categorical grants. Many public officials agree that the Federal Government should support weatherization activities for low-income households. The nature of this support, however, has been somewhat controversial. While some groups favor the block grant approach to Federal assistance, others find more merit in the categorical grant approach of the DOE program. At the State and local levels, however, the two programs often have the same or similar guidelines and often are administered by the same agencies.

For fiscal year 1986, the President recommended phasing out the DOE program, which would leave the LIHEAP block grant as the primary source for federally funded weatherization assistance. Congress, however, rejected the President's recommendation and funded the program in fiscal year 1986 just below its fiscal year 1985 funding level. The General Accounting Office reviewed the program and found that priority for weatherization is lower in the block grant programs, which could result in fewer homes being weatherized. In fiscal year 1986, States used 9 percent of the LIHEAP block grant for weatherization programs out of an allowed 15 percent. GAO also noted that a lack of restriction on how funds may be used could result in communities not effectively targeting funds to address the greatest need. Additionally, GAO stated that no evidence existed to support the notion of reduced costs and improved quality under the block grant approach.

States have statutory authority to transfer to LIHEAP up to 10 percent of their social services block grant allotments and up to 5 percent of their community services block grant allotments, although, no State has done so. On the other hand, the LIHEAP statute provides that a State may transfer up to 10 percent of the LIHEAP funds payable to it for a fiscal year for use in one or more of the six other block grants administered by DHHS. Thirty States transferred a total of approximately $87.3 million or 4 percent of LIHEAP funds to these block grants in fiscal year 1986. In 1987, 33

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[4] Hirst, Eric and Raj Talwar. "Reducing Energy Consumption in Low-Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, V.5, October 1981. pp. 671-683.

States transferred an estimated $93 million of LIHEAP funds to other block grants, 27 of them to the social services block grant.

C. LEGISLATION

Despite efforts by the Reagan administration to block grant or fund LIHEAP from petroleum overcharge funds rather than general revenues and to eliminate or phase-out the Department of Energy Weatherization Assistance Program, Congress steadfastly has resisted changes. For example, in the 1984 budget request, the Reagan administration proposed replacing LIHEAP with a block grant to States and requested no funding for the Weatherization Assistance Program. Although Congress has studied numerous energy assistance proposals, it has rejected the administration's approach and continued the programs.

1. LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

The current LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981: Public Law 97-35), as amended by the Human Services Reauthorization Acts of 1984 and 1986 (Public Law 98-558 and Public Law 99-425). The 1986 amendments authorized appropriations through fiscal year 1990 at gradually increasing levels of $2.05 billion for fiscal year 1987 to $2.307 billion for fiscal year 1990.

(A) REAUTHORIZATION OF LIHEAP

The administration's fiscal year 1987 budget request assumed extension of the appropriations authorization for LIHEAP, as did the fiscal year 1987 congressional budget resolution (S. Con. Res. 120). To extend the authorization of LIHEAP appropriations, the administration submitted draft legislation that proposed to:

(1) Extend the appropriations authorization for 3 years at $2.1 billion for fiscal year 1987 and with no specific authorization levels for later years.

(2) Remove the 15 percent limit on the proportion of a State's allotment that may be devoted to weatherization assistance,

(3) Repeal the requirement that States describe home energy usage within each State in their annual application for an allotment,

(4) Require States to take into account other assistance available to LIHEAP beneficiaries when establishing their LIHEAP benefits,

(5) Revise the method of calculating and providing special LIHEAP grants to Indian tribes, and

(6) Change certain nondiscrimination provisions of LIHEAP law.

However, Congress chose to design reauthorization legislation that, in effect, ignored many of the administration's recommendations.

In September 1986, House-Senate conferees on H.R. 3321 agreed on the 1986 reauthorization of LIHEAP (Public Law 99-425). It included the following provisions:

(1) A 4-year reauthorization of appropriations for LIHEAP with authorization levels increasing 4 percent a year:

	Billion
Fiscal year 1987	$2.050
Fiscal year 1988	2.132
Fiscal year 1989	2.218
Fiscal year 1990	2.307

(2) Provisions stipulating time deadlines that must be met in delivering energy crisis aid and making it clear that community based organizations such as community action agencies may be designated to administer energy crisis intervention programs.

(3) Revisions in the method of calculating and providing special LIHEAP grants to Indian tribes.

(4) Provisions emphasizing the requirement that States adjust benefits to ensure that the neediest households receive the maximum assistance.

(5) Provisions reorganizing State plan requirements and directing the development of a model State plan.

(6) A requirement for an annual report on LIHEAP.

(7) provisions stipulating that receipt of LIHEAP benefits do not affect eligibility or benefits under the Food Stamp Program. (See Food Stamp Chapter for details.)

(B) FUNDING LIHEAP

Appropriations for fiscal year 1988 of $1.5 billion have been cut sharply from the $2.1 billion for fiscal years 1985 and 1986. Congress approved this level in agreeing on the conference report of H.J. Res. 425 in December 1987 (Public Law 100-202).

For fiscal year 1987, $1.825 billion was appropriated, a cut of $184 million from the 1986 appropriation. For the fiscal year 1987 appropriation, House-Senate conferees explicitly stated that ". . . the amount agreed to for LIHEAP should not be construed as a decline either in support for the program or in the need for such assistance. Rather, it is reflective of the unusual circumstances which exist this year: Lower energy prices in general and the availability of substantial oil overcharge funds to the States."

Congress authorized $2.3 billion for LIHEAP in fiscal year 1986 but only $2.1 billion was actually appropriated. Since LIHEAP was subject to a 4.3-percent reduction under Gramm-Rudman-Hollings (Public Law 99-177), the amount actually available was $2 billion.

For fiscal year 1988, the administration proposed a $1.24 billion appropriation level for LIHEAP, a $585 million or 32-percent decrease from the appropriation for fiscal year 1987. The budget resolution for fiscal years 1988 and 1989, H. Con. Res. 93, approved by the House and Senate in June 1987 assumed current funding levels for LIHEAP. The House of Representatives also recommended funding the program in fiscal year 1988 at the same level as for fiscal year 1987, $1.825 billion (H.R. 3058; H. Rept. 100-256).

On the other hand, the Senate Appropriations Committee approved a level of $1.24 billion, the same as the administration's request (H.R. 3058; S. Rept. 100-189). This level was approved by the full Senate in October 1987 after failure of two floor attempts to raise the level to $1.825 billion. The chairman and members of the

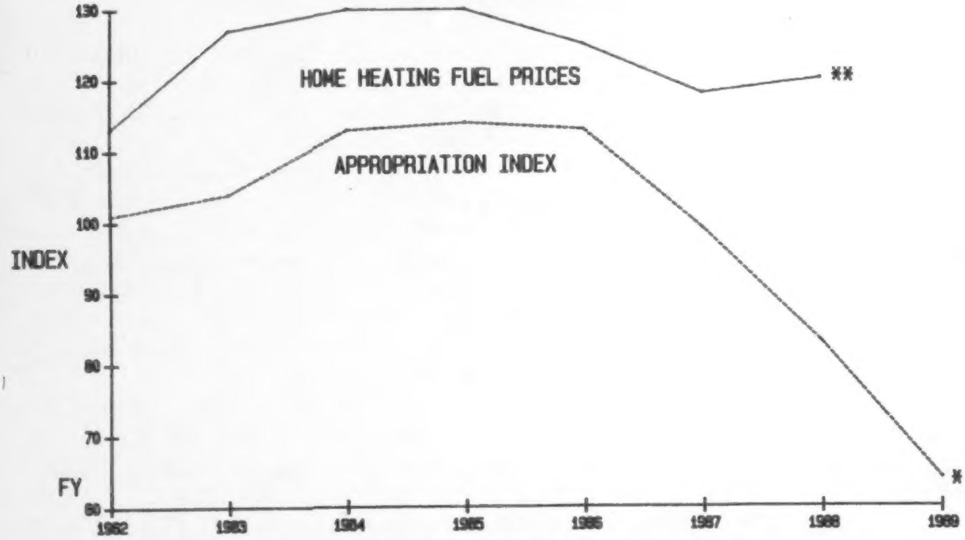
Senate Special Committee on Aging tried to stave off the cuts in the Appropriations Committee with letters to the chairman and members. A majority of Senate Members also signed a letter to conferees in support of the higher appropriations level approved by the House of Representatives.

Senate proponents of the lower level argued that oil overcharge funds were available to the States to make up the difference and cited the Senate appropriations bill for the Department of Labor, Health and Human Services, and Education, requiring a significantly lower outlay amount than the same House appropriations bill. They also noted that States continued to transfer almost $100 million from LIHEAP funds to other block grants.

Those opposed to the administration's proposed 32-percent cut and the conferees 16-percent cut noted the uncertainty of oil overcharge funds available to the States for the 1988 winter season as most State legislatures already had adjourned and allocated the money. They also cited the low percentage of eligible low-income households that actually receive LIHEAP benefits. Chart 3 illustrates appropriation levels for LIHEAP, the cost of home heating fuels and the CPI from 1981 through 1988.

CHART 2

INDEX OF HOME ENERGY COSTS AND LIHEAP APPROPRIATIONS
1982-1989



Source: National Community Action Foundation
** estimate
* administration budget request

(1) State Allotments

Although a new formula for allocating LIHEAP appropriations among the States was enacted in the 1984 amendments to the Low-Income Energy Assistance Act, the method of allocating funds actually varies according to the appropriation level. As a result, changes in appropriations can produce what appear to be anomalous differences in State allotments. In fiscal year 1986, some states experienced a decrease in their allotments because LIHEAP was subject to a Gramm-Rudman-Hollings spending reduction of 4.3 percent. Under the LIHEAP allocation procedures, 23 states received no reduction, 7 states and the District of Columbia received the standard 4.3 percent fiscal year 1986 Gramm-Rudman-Hollings reduction, and the remaining 20 states received cuts ranging from 4.6 percent to 11.7 percent. This was criticized by many as contrary to the uniform "across-the-board" intent of Gramm-Rudman-Hollings and a bill was introduced that would have directed uniform percentage cuts in State allotments when funding reductions are caused by Gramm-Rudman-Hollings procedures. Reductions in State allocations occurred again in 1987 because the annual LIHEAP appropriation is less than that of the previous year and will be cut significantly in 1988.

(2) Recouped Oil Price Overcharges

From 1973 to 1981, the United States imposed price controls on crude oil and petroleum products in response to the Arab oil embargo. Since then, a number of lawsuits have been filed against certain oil companies for alleged overcharges during that period.

Money recovered from oil companies in two recent major court decisions for oil price overcharges under the Emergency Petroleum Allocation Act of 1973 (Public Law 93-159) has been made available to the States as possible additional funding for LIHEAP and other energy-related programs. The courts stipulated a restitutionary principle originally adopted by Congress which requires that these funds be used to "supplement, not supplant" existing Federal and State resources. Each State decides how it will allocate the funds.

Under the 1985 $2.1 billion Exxon decision, States are to use the funds for LIHEAP and four other programs which include the Low-Income Weatherization Program, the Schools and Hospitals Weatherization Program, the State Energy Conservation Program, and the Energy Extension Service. All of these programs, except LIHEAP, are administered by the Department of Energy (DOE). States may use their allocations over a period of years. DOE, through its Office of Hearings and Appeals, also is requiring the States to spend their overcharge funds in a "balanced" manner.

The other case, the Stripper Well decision, has yielded about $800 million to the States to date and may yield up to $1 billion over the next few years. These funds may be used for LIHEAP and the other four energy conservation programs as well as a broader range of energy programs. In addition, States are required to spend "an equitable share" on low income programs.

More than $3 billion has been provided to the States in recouped funds, nearly all of it distributed in 1986. So far, States have designated $401.6 million or 17.8 percent for LIHEAP, including weatherization, and $465.1 million, or 20 percent for the Department of Energy Weatherization Assistance Program. Another $43 million has been allocated to other low income programs such as weatherizing public housing and homeless shelters and transportation for the poor and elderly. Most States have decided to allocate the actual spending of the overcharge funds over a number of years.

In fiscal year 1987, DHHS estimated the States used $187 million of the available overcharge funds for LIHEAP—$116 million on energy assistance and $71 million on the weatherization program. According to DHHS, the States used $27 million of the funds for LIHEAP in fiscal year 1986.

The first national distribution of oil overcharge funds was a $200 million settlement referred to as Warner amendment funds, named after the Senate sponsor of the legislation (section 155 of Public Law 97-377). Held in escrow by the Energy Department, they were distributed in early 1983. The money is allocated among the States according to each State's share of the national usage of petroleum products during the period of the oil price overcharges involved in the court settlement.

In 1985, an oil price overcharge award of $2.1 billion against the Exxon Corp. was upheld. In 1986, the Energy Department released the award to the States according to their usage of petroleum products. As of November 30, 1987, States reported allocating about 22 percent of these funds, or $364 million, for LIHEAP.

More recently, a 1986 Federal district court ruling approved a settlement in the so-called "Stripper Well" case. The first and largest distribution was $753 million.

Although the settlement potentially involved a total of $4 to $5 billion, $500 million was designated to be paid to major fuel users (airlines, railroads, etc.) and the balance of the settlement will be split evenly between the States and the Federal Government. A large share of the potential distribution is owed by Texaco, which currently is in chapter 11 bankruptcy.

Another $49 million in Diamond Shamrock overcharge funds were disbursed by DOE in 1986 and a disbursement of about $90 million of Stripper Well funds went to the States in 1987. Additional Stripper Well distributions to the States may be close to $960 million, but likely will be distributed over the next few years.

The availability of money from recouped oil overcharges has become an issue with regard to LIHEAP. To the extent that States have access to this money and use it to fund LIHEAP efforts, it is argued that Federal appropriations can be frozen or reduced. Indeed, the Senate reduced appropriations for both fiscal years 1987 and 1988 in recognition of overcharges. Rather than reduce Federal appropriations, some argue that any Federal share of the recouped overcharges should be earmarked to fund LIHEAP.

Those who disagree with these positions argue that the availability of oil overcharge funds should not affect appropriations for LIHEAP or the DOE Weatherization Assistance Program. They state that oil overcharge funds are neither Federal nor State funds, but represent lost resources by purchasers across the country as a result of illegal action. Since they are intended to remedy past injuries, they should be applied in a way that addresses those past injuries and should not be used to replace current funds in on-going Federal programs. They also argue that through the Warner amendment, congressional intent, reinforced by the courts, made the oil overcharge money available to the States to be used in addition to (not instead of) existing Federal and State money for five designated Federal programs.

In addition, many States have spent a larger amount of their overcharge funds on weatherization programs, arguing that these are long term investments that reduce the need for energy assistance. Many State legislatures also have allocated the overcharge funding and could not reconvene in time to appropriate for the 1988 winter after Congress made the final decision for significant cuts in the LIHEAP appropriations in 1987.

As more oil price overcharge funds become available to the States, it is uncertain what effect the availability of this recouped money will continue to have on Federal appropriations over the long term and on State support for LIHEAP beyond Federal allotments of LIHEAP funds.

(C) WEATHERIZATION

In his fiscal year 1986 budget request to Congress, the President recommended a $152.9 million funding level for the DOE Weatherization Assistance Program with a plan to phase out the program over a 5-year period. The President also recommended helping States develop strategies for conducting weatherization activities without Federal assistance during the phaseout period. In response to this recommendation, DOE began to help States with techniques for carrying out weatherization activities without Federal funds and awarded 38 "opportunity grants" ranging from $40,000 to $60,000 each to State and local agencies for demonstrating strategies to weatherize homes without Federal funds.

Congress, however, has not acted on the President's request to phase out the program. The program operated at a level of $161 million in fiscal year 1987 and will have the same allocation for fiscal year 1988. In fiscal year 1986, revenues dropped to $178 million from the $182 million appropriation, reflecting reductions under Gramm-Rudman-Hollings.

For fiscal years 1987 and 1988, the President proposed phasing out Federal assistance for the Department of Energy Weatherization Assistance Program in future years and funding was proposed to come from settlement of petroleum pricing violation cases.

D. PROGNOSIS

There is clear evidence that Federal energy assistance programs have been successful in providing emergency relief and basic energy needs to millions of elderly and poor Americans. These programs have also reduced the energy expenditures for many of the poor through weatherization assistance. The level of the programs' success and their philosophical appropriations, however, continue to be debated.

Nonetheless, the energy expenses of the elderly and poor will continue to grow during the next decade, creating a wider gap between their needs and the Federal Government's response. According to the Community Action Foundation (CAF) 4 million households had utility service terminated for nonpayment in 1982. To prevent service terminations from increasing and to keep the percentage of real income devoted to energy by the poor at a manageable level, billions of dollars in assistance will be needed. CAF estimates that if energy costs grow 2 percent per year, the eligible population would need $7.3 billion in 1989, just to maintain its purchasing power.

The Alliance to Save Energy has demonstrated that cost-effective low-income conservation programs are possible through installation of new heating system technologies. The development and field testing of much of the new heating system technologies was supported through Federal research and development efforts. Funding for these research activities has been decreasing in recent years, even though these investments in research could result in saving elderly households millions of dollars in energy costs. The availability of research funds will play an important role in determining future conservation successes.

In the past few years, many gas and electric utilities have been required by State public utility commissions to undertake low-income and elderly conservation programs. These programs could have a positive effect on the energy needs of the elderly. This approach encourages greater State and local control and funding of such conservation activities.

It is obvious to those who know the administration's philosophy regarding domestic spending and the current mood in Congress, that appropriations at levels to meet eligibility and research needs will not be forthcoming. In fact, it is probable that both LIHEAP and the DOE Weatherization Assistance Program will be targeted again in fiscal year 1989 by the administration and/or Members of Congress for cuts or elimination. Continued congressional support and expanded private efforts will be needed to preserve the current levels of assistnace.

It is unclear what the impact of changing oil prices will have on consumers of home heating fuels, but overall home fuel costs are continuing to rise. Congressional perception that oil overcharge funds will continue to be available to the States for use in LIHEAP and weatherization programs undoubtedly will remain the largest deterrent to full restoration of the 27 percent reduction in appropriations over the past 3 years. The amount that States will receive from future oil overcharge cases is uncertain. But it is apparent that they will not receive another large distribution like the Exxon and Stripper Well disbursements in 1986 and future, smaller distributions will be made in a series over a number of years. Another variable in addition to the Congress, home heating costs and oil overcharge allocations, is the weather. These questions aside, what is clear is that millions of eligible families will continue to be underserved.

Chapter 12

OLDER AMERICANS ACT

OVERVIEW

For the past 22 years, the Older Americans Act (OAA) (the Act) has served as the cornerstone of Federal involvement in a wide array of community services to older persons. Created during a time of rising societal concern for the needs of the poor, the Act marked the beginning of a categorical approach to programs specifically designed to meet the social and human needs of the elderly. The Act itself was one of a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the health and income-transfer programs. Although older persons could receive services under a number of other Federal programs, the Act became the first major vehicle for the organization and delivery of community-based social services to older persons.

The Older Americans Act followed on the heels of a similar but somewhat more expansive grouping of social service programs initiated under the Economic Opportunity Act of 1964. With a conceptual framework similar to that embodied in the Economic Opportunity Act, the Older Americans Act was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When first enacted in 1965, the Act established a series of broad policy objectives designed to meet the needs of older persons. These objectives, however, lacked both legislative authority and adequate funding. The 1965 Act, however, established a structure through which the Congress would later expand aging services.

Over the years, the essential mission of the Older Americans Act has remained very much the same: To provide a wide array of social and community services to those older persons in the greatest economic and social need in order to foster maximum independence. The key philosophy of the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization. Some of the services supported under the Act include congregate and home-delivered meals, senior centers and nursing home ombudsman activities, and community service employment programs.

Funding for the OAA grew slowly during the 1960's, but during the 1970's Congress followed up on improvements in income-transfer programs with significant modifications to the Act by adding authority for the creation of area agencies on aging (AAA's) and for a program of community service employment. AAA's, authorized by legislation enacted in 1973 along with the State units on aging, constitute the administrative structure for programs under the Act. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system that will best meet these needs. As originally conceived by Congress, this system was meant to encompass both services funded under the Act, and services supported by other Federal, State, and local programs. The purpose of the community service employment program is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. The program, administered by the Department of Labor, awards funds to national organizations and to State agencies to operate the program.

In 1974, a national nutrition program for older Americans was created. Fiscal years 1978 and 1981 saw further improvements in the level of financial support directed toward Older Americans Act programs, continuing development of the structures for providing community-based services (AAA's) and the added emphasis on the provisions of certain priority services, such as access (transportation, outreach, and information and referral), in-home and legal services.

This expansion trend continued until the early 1980's, when, in response to the Reagan administration's policies to cut the size and scope of many Federal programs, the growth of OAA spending was slowed substantially, and for some programs was reversed. For example, between fiscal years 1981 and 1982, title IV funding for training, research, and discretionary programs in aging were cut by approximately 50 percent. However, widespread congressional support for other OAA programs, especially nutrition and senior employment, served to protect them. This broad congressional support for OAA programs continued during the 1987 reauthorization of the Act and can be expected to continue in the future.

A. MAJOR ISSUES IN OAA REAUTHORIZATION OF 1987

Prior to and during the first session of the 100th Congress, a series of issues under the various titles of the Act were examined by the Administration on Aging, the Federal Council on the Aging, a number of congressional committees including the Special Committee on Aging, and local and national aging advocacy organizations including the National Association of State Units on Aging and the National Association of Area Agencies on Aging. The following is a summary of some of the primary issues which were raised during the Older American's Act reauthorization process.

1. Change Age Factors for Distribution of Title III Funds From 60 to 65 Years

In the early stages of the reauthorization process, the Reagan administration proposed changing the formula for the allotment of title III funds to States so that States would receive funds on the basis of its population aged 65 years or over instead of 60 years or over as provided by current law. Under this proposal, the program would continue to serve those age 60 and over, but title III funds would be allocated to each State based on its share of the population aged 65 or over as compared to all States. The administration's rationale was that with limited funding, the programs should focus on the most vulnerable.

Congress rejected the proposal to change the formula for several reasons. One reason was that the effect of the proposal not only potentially could decrease the amount of overall appropriations, but also could change the demographics of how the funds would be allocated. While some States would gain funding, other States would lose money under the age-65-based formula. The administration's recommendation also was rejected on the basis that vulnerability cannot be measured on the basis of age alone. It also was suggested that many persons in their seventies and eighties today are healthier than those of the same age a decade ago because of increased emphasis on health promotion, disease prevention and consumer awareness programs. Other examples frequently cited were the advantages gained from nutrition programs, both congregate and home-delivered. In addition, it was believed that changing the distribution formula would have a negative impact on minority elderly whose life expectancy is less than that of non-minorities.

2. CONSOLIDATION OF FUNDS AND PROGRAMS

In its fiscal year 1988 budget request, the administration did not submit a request for a dollar amount reauthorization for OAA programs. Instead, it requested a generic appropriation of $2.2 billion for 26 separate discretionary activities, including OAA programs, under the Office of Human Development Services. Congress viewed this as an attempt to "block grant" the OAA programs, which could significantly reduce funding.

The OAA provides for separate authorizations for each title under the Act and, within title III for separate programs. Generic funding was seen as altering the entire structure of the program. In addition, the Federal Government would lose important information about trends in the aging population's needs for services.

The administration also proposed consolidating the programs under the Act's titles, particularly titles III and IV, into one. The administration reasoned that single authorizations would provide greater flexibility for State offices on aging and also would make it easier for State and area agencies on aging to submit funding plans.

Opponents of this proposal argued that separate authorizations for such programs as supportive services, congregate meals, and home-delivered meals enabled these programs to maintain greater visibility which, in turn, produced more realistic appropriations. It also was argued that there already is flexibility under the program to shift funds under title III. Under the law in effect at the time of consideration of the amendments, States could transfer up to 30 percent of their separate allotments between the nutrition program and supportive and senior center programs. In addition, regulations allowed States to transfer up to 30 percent of their separate allotments for congregate and home-delivered meals programs between such allotments.

Congress not only rejected the administration proposals, retaining separate appropriations for the programs under the Act, but also authorized six additional authorizations of appropriations for services under title III.

3. COST-SHARING OR FEE-FOR-SERVICE

During reauthorization hearings, the administration's proposal included a provision which would authorize States, at their option, to permit area agencies on aging to charge fees, based on ability to pay, for supportive services under part B of title III. It was to be left to the State's discretion to determine which supportive services would be subject to charges.

Organizations representing States and area agencies on aging submitted their own proposal for amendments to allow State agencies on aging to establish procedures for either voluntary or mandatory cost-sharing for selected services under title III and allow area agencies on aging to solicit voluntary contributions. The State and local levels of the aging network are increasingly pressed to find alternative sources of funding to supplement the limited availability of Federal funding and continue to provide needed services. In addition, the State and area agencies in advocating the cost-sharing proposal, believed that a sliding fee scale would allow coordination of OAA program services with other services that are means-tested in some way. It was argued that cost-sharing would permit an increased level of services without increasing Federal funding, and could be structured to increase services to those most in need, thus increasing low-income and minority participation in title III programs. Some services, such as referral, outreach, advocacy and ombudsman services, were to be exempt as well as those persons who had incomes of less than 125 percent of the poverty level.

This latter proposal, which drew sharp opposition, later was amended to request that a limited number of States be given authority to conduct studies on cost-sharing in the programs under the Older Americans Act. Cost-sharing or fee-for-service, however, is viewed by many in Congress as either a preliminary step to or a pseudonym for means-testing. There was concern that cost-sharing would produce an unintended opposite effect causing participation of the neediest individuals to decline due to either a misunderstanding of the cost-sharing requirements or an unwillingness to disclose financial information.

Because the Older Americans Act was intended to be the major vehicle for the organization and delivery of community-based services to all older Americans regardless of income, Congress has consistently rejected any attempts to introduce means-testing and did so again during the 1987 reauthorization. However, the Senate Committee on Labor and Human Resources requested the General Accounting Office to study current State cost-sharing systems and report its findings to the committee by September 30, 1990.

4. TARGETING

Another major issue during the 1987 reauthorization process was how to improve targeting and outreach to certain subgroups of older persons, particularly low-income minority persons. Although the Act has required that State and area agencies on aging are to give preference to the elderly with the greatest economic or social need, with particular attention to low-income minority individuals, many advocates stressed it should be specified in all relevant sections of the law to ensure that the preference actually was achieved.

The reauthorization hearings documented that participation by minorities in title III programs had declined by a disturbing 27 percent since 1981. Reasons cited for the decline included that minority persons often felt that OAA programs were not responsive to their needs and priorities, meals were not culturally appropriate, non-English publications seldom were available and there was insufficient publicity about OAA programs and referral services. Additional reasons given were that outreach to minority older persons by area agencies on aging was poor and the minorities were absent or excluded from the service delivery planning process on local advisory councils.

In response to these concerns, the 1987 Older Americans Act reauthorization incorporated a number of provisions designed to strengthen prior law requirements with respect to planning and service delivery for elderly minority persons. These provisions include requirements that State and area plans on aging identify the number of low-income and minority older persons in the State or planning and service area, and describe methods used to meet their needs in the previous year. Another new provision to address this issue requires service providers to specify how they will meet the needs of low-income minority older persons and to attempt to provide services to such individuals in at least the same proportion as they represent the total older population in the area.

President Reagan, in signing the 1987 amendments into law, expressed his opposition to these changes by questioning the constitutionality of the targeting provisions.

B. THE OLDER AMERICANS ACT AMENDMENTS OF 1987 [1]

Authorization of appropriations for the Older Americans Act (OAA) of 1965, as amended, expired at the end of fiscal year 1987. Public Law 100–175, the Older Americans Act Amendments of 1987, providing a 4-year reauthorization, through 1991, was enacted on November 29, 1987.

The following is a brief description of key provisions added to each title of the Older Americans Act in 1987:

1. Title I—Declaration of Objectives

Title I outlines broad social policy objectives aimed at improving the lives of all older Americans in a variety of areas such as income, health, housing, and long-term care. The amendments added an additional objective, the protection of the elderly from abuse, neglect, and exploitation.

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[1] For a more detailed description of the 1987 Older Americans Act Amendments, see U.S. Senate Special Committee on Aging Committee Print 100–C.

2. TITLE II—ADMINISTRATION ON AGING

Title II establishes the Administration on Aging (AoA) to administer most Older Americans Act programs and to act as the chief Federal agency advocate for older persons. It also establishes the Federal Council on Aging to advise the President and Congress regarding the needs of older persons.

The issue of the organizational status of the AoA has been a recurring one during previous OAA reauthorizations due to concern that AoA, because it is located within the Office of Human Development Services, does not have the visibility to effectively advocate on behalf of the elderly on a broad range of issues. The 1987 amendments addressed this concern by elevating the status of the Commissioner within the Department of Health and Human Services. The Commissioner now will report directly to the Secretary, as compared to the prior law provision which required the Commissioner to report to the "Office of the Secretary."

The Commissioner also is to establish within AoA a new Office for American Indian, Alaskan Native and Native Hawaiian Programs to be headed by an Associate Commissioner. In addition, the amendments added a number of new provisions requiring increased data collection by AoA.

With respect to the Federal Council on Aging, the law now requires that 9 of the 15 members be older persons as compared to prior law which required that 6 of 15 members be older. The Council also is to have representation from Indian tribes.

3. TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING

Title III establishes authority for the network of State and area agencies on aging and requires the development of a comprehensive and coordinated services system for older persons.

Under prior law, title III contained three parts authorizing funds to State agencies on aging for supportive services (part B), congregate nutrition services (part C-1), and home-delivered nutrition services (part C-2). Although the 1987 OAA amendments made certain changes relating to the administration of these services by State and area agencies on aging, the major amendments included a number of new authorizations of funds for a number of programs. These programs areas are:

Nonmedical in-home services for the frail elderly under a new part D,

Services to meet the special needs of the elderly under a new part E,

Health education and promotion activities under a new part F,

Elder abuse prevention activities under a new part G,

Long-term care ombudsman services, and

Outreach services to older persons potentially eligible for Supplementary Security Income, Medicaid, and Food Stamp Programs.

While State and area agencies have had responsibilities in these areas under prior law, separate authorizations of title III funds were not specified. Except for in-home services for the frail elderly, the amendments include a funding trigger that requires that the funds for the new authorizations may not be appropriated unless total appropriations for programs in effect in fiscal year 1987 increase by at least 5 percent. These funding restrictions are in effect through fiscal year 1990.

Under prior law, each area agency on aging was to provide assurances that it would spend an "adequate proportion" of its allotted funds for supportive services on three categories considered as priorities under the area plan. These are (1) access services (transportation, outreach and information and referral), (2) in-home services (homemaker and home health aide, visiting and telephone reassurance, chore maintenance, and supportive services for families of elderly victims of Alzheimer's and related diseases), and (3) legal assistance. The 1987 amendments changed this requirement to stipulate that each State agency is to set a minimum percentage of funds to be used for these three service categories by each area agency.

Several amendments require the coordination of title III services on behalf of specific groups of older individuals. Various provisions focus on the needs of persons with mental illness, victims of Alzheimer's disease and their families, persons with disabilities, and those in need of community-based long-term care services.

Other new title III provisions require State and area agencies on aging to focus on the needs of older Indians, including requirements that the distribution of this group be considered when planning services with the State and the planning and service area. The law also added a new provision requiring area agencies to conduct outreach activities to identify older Indians and inform them of services under the Act if their population is significant within the planning and service area. Finally, other provisions were added to clarify the eligibility of Indians to receive services under both title III and the title IV grant programs.

4. TITLE IV—TRAINING, RESEARCH AND DISCRETIONARY PROJECTS AND PROGRAMS

The title IV program authorizes the Commissioner to award funds for a broad array of training, research and demonstration programs in the field of aging.

The 1987 amendments added several new demonstration authorities, including areas related to health education and promotion, volunteerism, coordination of the long-term care ombudsman program with protection and advocacy systems for the disabled, and consumer protection activities in long-term care. For the latter two, the amendments authorized separate funding amounts distinct from the overall title IV funding. The funding of long-term care gerontology centers was made mandatory. These centers previously were supported at the discretion of the Commissioner.

5. TITLE V—COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

The Community Service Employment Program authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons 55 years of age or older. Funds are awarded to eight national organizations and to State agencies. Enrollees are paid at the Federal or State minimum wage or the local prevailing rate of pay for similar employment.

The 1987 amendments set the allowable administrative cap for the program at 13.5 percent, but retained a prior provision allowing the Secretary of Labor to raise the cap to 15 percent. Also, a new provision was added to exclude title V wages received by enrollees from consideration when determining eligibility for Federal housing and Food Stamp Programs. In addition, a provision authored by Senator Melcher, Chairman of the Senate Special Committee on Aging, requires the Secretary of Labor and title V grantees to distribute to program participants information to help them identify age discrimination and to understand their rights under the Age Discrimination in Employment Act. Finally, some title V funds are to be reserved for national Indian aging organizations and national Pacific Island and Asian American aging organizations in the first fiscal year in which title V appropriations exceed the fiscal year 1987 level.

6. Title VI—Grants for Native Americans

Prior to the enactment of the Older Americans Act Amendments of 1987, title VI of the Act authorized funds for grants to Indian tribes for supportive and nutrition services that are comparable to those provided under title III. The amendments expanded the title to include a new part B authorizing funds for Native Hawaiians.

The 1987 amendments included two changes to prior law provisions on eligibility of Indians for title VI services. The first provision amended the law to make a tribal organization eligible for title VI funds if it has at least 50 older Indians, as compared with the prior provision which specified that tribal organizations must have at least 60 older Indians to receive funds. Second, the amendments eliminated prior law provisions prohibiting individuals or tribal organizations receiving services or funds under title VI from also benefiting from the title III program. As amended, the law now allows older Indians to receive assistance under both the title VI and title III programs.

The amendments added a new part B, the Native Hawaiian Program, and specified separate authorizations of appropriations for it within the overall authorization amount for title VI.

7. Other Provisions

(A) REPEAL OF TITLE VII

Title VII, Older Americans Personal Health Education and Training Program, added to the Act in 1984, has never received an appropriation and was repealed by the 1987 amendments. However, an amendment was added to title IV to preserve its intent. That provision authorizes the Commissioner to commit funds to institutions of higher education to develop prototype health education and promotion programs to be used by the network on aging.

(B) 1991 WHITE HOUSE CONFERENCE ON AGING

The 1987 amendments authorized the President to call a White House Conference on Aging in 1991 to increase public awareness of the contributions of older individuals to society, to identify problems as well as the well-being of older individuals, to develop recommendations for the coordination of Federal policy with State and local needs, to develop specific and comprehensive recommendations for both executive and legislative action to maintain and improve the well-being of older individuals and to review the status of recommendations adopted at previous White House Conferences on Aging.

The conference will bring together representatives of Federal, State, and local governments, persons working in the field of aging, and the general public, particularly older persons. The new provisions also set forth requirements regarding delegate selection, committee composition, conference agenda, and reporting requirements.

(C) CONSUMER PRICE INDEX FOR OLDER AMERICANS

Another provision, authored by Senator Melcher, requires the Secretary of Labor to develop an index of consumer prices to reflect the consumption expenditures for persons 62 years of age or older. This index and a report on the research necessary to develop and accurately measure the rate of inflation for older persons is to be provided to Congress by June 1988.

(D) AMENDMENT TO THE NATIONAL SCHOOL LUNCH ACT

Another provision introduced by Senator Melcher amends the National School Lunch Act to permit adult day care centers to receive reimbursement under the Child Care Food Program for meals or meal supplements (snacks) to persons 60 years or older or to chronically impaired disabled persons.

C. OAA AUTHORIZATION AND APPROPRIATIONS LEVELS

The 1987 amendments to the Older Americans Act (Public Law 100-175) provided for the following authorization levels from fiscal year 1988 through fiscal year 1991:

TABLE 1.—OLDER AMERICANS ACT AUTHORIZATION LEVELS, FISCAL YEARS 1987–91

[In thousands of dollars]

Act title	1987 (Public Law 98–459)	1988 [10]	1989 [10]	1990 [10]	1991 [10]
Title II					
Federal Council on the Aging	$200	$210	$221	$232	$243
Title III					
Grants for State and community programs on aging:					
Supportive services and centers	361,500	379,575	398,554	418,481	439,406
Nutrition services	614,600	645,130	684,837	727,778	773,017
—congregate	(395,000)	(414,750)	(435,488)	(457,262)	(480,125)
—home delivered	(75,600)	(79,380)	(83,349)	(87,516)	(91,892)
—USDA commodities	(144,000)	[1] (151,000)	[1] (166,000)	[1] (183,000)	[1] (201,000)

TABLE 1.—OLDER AMERICANS ACT AUTHORIZATION LEVELS, FISCAL YEARS 1987–91—Continued

[In thousands of dollars]

Act title	1987 (Public Law 98–459)	1988[10]	1989[10]	1990[10]	1991[10]
In-home services for frail elderly	(2)	25,000	26,250	27,563	28,941
Assistance for special needs	(2)	[3] 25,000	[3] 25,000	[3] [4] Such sums	[3] [4] Such sums
Health education	(2)	[3] 5,000	[3] [4] Such sums	[3] [4] Such sums	[3] [4] Such sums
Elder abuse prevention	(2)	[3] 5,000	[3] [4] Such sums	[3] [4] Such sums	[3] [4] Such sums
Long-term care ombudsman	(2)	[3] 20,000	[3] [4] Such sums	[3] [4] Such sums	[3] [4] Such sums
Outreach for SSI, Medicaid, and food stamps	(2)	....	[3] 10,000	[3] 10,000	....
Title IV					
Training, research, and discretionary projects and programs	31,400	32,970	34,619	36,349	38,167
Home care demonstration projects	(2)	....	[3] 2,000	[3] 2,000	....
Ombudsman and advocacy demonstration projects	(2)	....	[3] 1,000	....	....
Title V					
Community service employment for older Americans	[5] 368,300	386,715	406,051	426,353	447,671
Title VI					
Grants for Native Americans	[6] 8,600	[7] 13,400	[7] 16,265	[7] 19,133	[7] 22,105
Part A—Indian program	....	(12,100)	(14,900)	(17,700)	(20,600)
Part B—Native Hawaiian program	(2)	(1,300)	(1,365)	(1,433)	(1,505)
Title VII					
Older Americans personal health education and training program	[4] Such sums	(8)	(8)	(8)	(8)
Total	[9] 1,384,600	[9] 1,538,000	[9] 1,604,797	[9] 1,667,889	[9] 749,550

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[1] The law requires the Secretary of Agriculture to maintain a reimbursement level of 56.76 cents per meal for fiscal years 1986–91.

[2] Not authorized.

[3] The law requires that total appropriations for programs funded in fiscal year 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[4] Such sums as may be necessary.

[5] Plus such additional sums as may be necessary to maintain at least 62,500 employment positions.

[6] These finds were authorized for grants to Indian tribes. Under the law in effect in fiscal year 1987, this title was called Grants for Indian Tribes.

[7] The law creates a separate part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for part A, the Indian Program, and for part B. The law further specifies that part B receive funding only if the total appropriations for title VI exceed the fiscal year 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the fiscal year 1987 level, and half of any increase above the first $250,000 up to the authorized amount.

[8] This title is repealed.

[9] Plus such sums as may be necessary for certain programs.

[10] As contained in Public Law 100–175.

Source: Congressional Research Service.

As noted previously, the Reagan administration's fiscal year 1988 budget request for OAA programs was in the form of a proposal of a generic appropriation of $2.2 billion for 26 separate discretionary programs under the Office of Human Development Services, including OAA programs. Because of the concern that this financing approach would make the Older Americans Act a block grant program, this proposal was rejected by the Congress. The fiscal year 1988 continuing resolution appropriations bill (Public Law 100–202) funded the Older Americans Act programs at a level of $1.2 billion for fiscal year 1988. The following table provides a specific breakout by major title areas:

Table 2.—Older Americans Act Appropriations, Fiscal Year 1988

[In thousands of dollars]

Title II: Federal Council on Aging	191
Title III:	
Supportive services and senior centers	[1] 269,029
Nutrition services:	
Congregate	344,664
Home-delivered	75,635
USDA commodities	140,312
In-home services for frail elderly	4,787
Subtotal, Title III	834,618
Title IV: Training, research, and discretionary projects and programs	23,935
Title V: Community Service Employment	331,260
Title VI: Grants for Native Americans	7,181
Total	1,196,994

[1] This includes $957,000 Congress appropriated for the ombudsman program despite authorizing legislation requiring an appropriations trigger.

Source: Congressional Research Service.

D. OTHER CONGRESSIONAL ACTIVITIES DURING OAA REAUTHORIZATION

During consideration of H.R. 1827, the 1987 supplemental appropriations bill (Public Law 100–71), Senator Melcher offered an amendment to allow the transfer of previously appropriated but unused funds from the surplus commodities program to the home-delivered meals program under part C of title III. The transfer of the $1.4 million, which was approved by the Senate, allowed for an additional 500,000 meals during 1987.

Another amendment to the supplemental appropriations bill which was accepted was offered by Senator Heinz. Senator Heinz' amendment provided for an additional $10 million for title V of the Older Americans Act, Community Service Employment for Older Americans. This provided for an additional 1,960 employment slots for older Americans during 1987.

During Senate consideration of H.R. 3058, the Departments of Labor, Health and Human Services, and Education appropriations bill, Senator Melcher offered an amendment to provide for the Secretary of Health and Human Services to carry out not less than three demonstration projects to test and evaluate the feasibility of expanding the activities of the ombudsman program funded under the Older Americans Act to in-home services. The in-home services are to include those provided under the OAA, Medicare, Medicaid, and the Social Services Block Grant programs. The amendment was adopted by the Senate on October 14. Appropriations were subsequently incorporated in the continuing resolution (Public Law 100–202) under appropriations for Older Americans Act programs in the amount of approximately $1 million.

E. PROGNOSIS

Fiscal year 1988 will mark the 23d anniversary of the Older Americans Act. When first enacted in 1965, the OAA set out a series of objectives aimed at improving the lives of older Americans in such areas as income, health, housing, employment, community services, and gerontological research and education. Since its inception, the gradual evolution of the programs and services authorized by the Act has been remarkable. Although progress has been realized, it has not been without some growing pains.

As originally conceived, the congressional intention underlying the Older Americans Act was to establish a coordinated and comprehensive system of services at the community level. Such a system, it was asserted, would provide opportunities for and assist vulnerable older persons who, despite advancements in income security and health programs, still needed social services support. Additionally, the structures would provide the supports necessary to promote independent living and reduce the risk of costly institutionalization.

To that end the Older Americans Act has been successful. The needs of older persons have been identified and the means for meeting those needs have evolved concurrently. There is now an "aging network" of 57 State units on Aging, over 600 area agencies on aging and 10,000 associated service-providing agencies coordinating and providing community-based services. Additionally, the Act has been the vehicle for the education and training of thousands in the field of aging.

Despite the increase in authorizations for existing programs and adequate authorizations for new programs with the 1987 reauthorization, the programs operated under the Older Americans Act will continue to be overextended and underfunded. Area agencies on aging out of necessity must raise funds from many other sources to support the programs.

Targeting the available resources to specific categories of older persons, those most in need, is a natural consequence of limited funding. It is also inevitable that those who are most pressed for funding resources on the State and local levels will continue to advocate cost-sharing. However, even if cost-sharing was implemented, it is unlikely to generate sufficient funds to finance services necessary to successfully address the many unmet needs of numerous older Americans.

Although the Act prohibits the direct provision of services by an area agency on aging, a waiver may be obtained where the State unit on aging determines either that there is no other agency or organization in the area to provide the services or that the area agency on aging can provide the service more economically. Emphasis on the development of long-term care strategies and assuming increasing responsibilities for case management and preadmission assessment have propelled State and area agencies into new functional areas and it is likely that this trend will continue in the future.

Without question, future demographic pressures will place increasing burdens on the delivery systems under the Older Americans Act. The challenge for State and area agencies on aging will be not only to maintain necessary services, but also to assure the quality and accessiblity of these services. As has been the case in the past, with continued broad support from the Congress, the OAA can be expected to adapt to and be strengthened from these challenges in the years to come.

Chapter 13

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, and volunteer opportunitites for older Americans.

During the Reagan administration, two basic themes have emerged with respect to the delivery of social services for the elderly. First, the administration has sought to give States greater discretion in the administration of social services as part of its "New Federalism" initiatives. Second, the shift toward block grant funding has been accompanied by a general trend toward fiscal restraint and retrenchment. As a result, the competition for scarce resources has been accelerated between the elderly and other needy groups. In addition to cuts accompanying the block grants, the administration has proposed to reduce spending for education, transportation, and legal services. Fiscal restraint in these programs has affected service delivery in varying degrees, with the most significant cuts coming in legal services, which the administration has sought to eliminate entirely. Older American Volunteer Programs, by contrast, have enjoyed strong support from the administration.

For the most part, Congress has resisted the administration's efforts to reduce funding for social, community, and legal services. Following the cuts sustained in the fiscal year 1981 budget, Congress increased spending for the Social Services Block Grant, Community Services Block Grant, and legal services. In fiscal year 1985, Congress significantly increased authorized spending levels for adult education and other education programs benefiting the elderly. The focus on Federal spending, however, is now clearly framed by the widespread concern over budget deficits. Advocates of human service programs are hopeful that the new Democratic majority in the Senate will be able to direct more resources toward social service programs. The likelihood of this is unclear considering the limitations created by the Gramm-Rudman-Hollings legislation and an apparently strong desire to avoid initiating tax increases. The resolution of this debate may very well determine the Federal role in providing social services to the elderly in the years ahead.

A. BLOCK GRANTS

1. BACKGROUND

(A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-dollar match of State social services funding. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration.

Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded and certain day care services which received 100 percent Federal funds. Training also was matched at a 75 percent Federal rate. Significantly, the law required that at least half of each State's Federal allotment be used for services to recipients of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 percent and 115 percent of the State median income. States also were required to follow a specified planning and public participation process.

In 1981, Congress created the Social Services Block Grant (SSBG) as part of the Omnibus Budget Reconciliation Act. By eliminating most of the restrictions in title XX, Congress granted the Reagan administration added flexibility to transfer maximum decision-making authority to the States and reduce domestic Federal spending. Under the block grant program, States no longer are required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated and Federal standards for services, particularly for child day care, also were dropped. The block grant allows States to design their own mix of services and to establish their own eligibility requirements.

Block grant funds are used for such diverse activities as child day care, home-based services for the elderly, protective and emergency services for children and adults, family planning, transportation, staff training, and program planning.

(B) COMMUNITY SERVICES BLOCK GRANT

The Community Services Block Grant (CSBG) is the current version of the Community Action Program (CAP), which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity within the Executive Office of the President. In 1975, the Office of Economic Opportunity was renamed the Community Services Administration (CSA) and reestablished as an independent agency of the executive branch.

As the cornerstone of the agency's antipoverty activities, the Community Action Program gave seed grants to local, private nonprofit, or public organizations designated as the official antipoverty agency for a community. These community action agencies were directed to provide services and activities "having a measurable and potentially major" impact on the causes of poverty. During the agency's 17-year history, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low-income energy assistance and weatherization. Although the agency's budget peaked in fiscal years 1969 and 1970 with an annual funding of $1.9 billion, the funding then steadily declined until fiscal year 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, the CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. Programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at both the State level and the point of delivery.

In 1981, the Reagan administration proposed elimination of the CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and a congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Reconciliation Act of 1981 abolished the CSA as a separate agency, but replaced it with the CSBG to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

The CSBG Act requires States to submit an application to the Department of Health and Human Services, promising the State's compliance with certain requirements, and a plan showing how this promise will be carried out. States must guarantee that legislatures will hold hearings each year on the use of funds. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs and to encourage the use of private-sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Head Start, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Funding for the new block grant in fiscal year 1982 amounted to a 30 percent reduction from the CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of the CSA.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act offered States the option of not administering the new CSBG during fiscal year 1982. Instead, the Department of Health and Human Services would continue to fund existing grant recipients until the States were ready to take over the program. States which opted not to administer the block grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior grant recipients. In the act, this 90 percent pass-through requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision to ensure program continuity and viability. The extension was viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they administer. Four states—Wyoming, Utah, Nevada, and Colorado—qualified for an exemption because a significant number of their counties were not served by an existing Community Action Agency. Congress in 1984 made the 90 percent passthrough requirement permanent and applicable to all States, under Public Law 98–558. Currently 860 agencies receive funds under the 90 percent pass-through.

2. Issues

(A) NEED FOR COMMUNITY SERVICES BLOCK GRANTS

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG suggested fewer restrictions. According to the administration, States then would be able to develop the mix of services and activities that were most appropriate to the unique social and economic needs of their residents.

However, a General Accounting Office (GAO) report refutes this claim.

In May 1986, GAO issued a report on the operation of Community Action Agencies (CAA's) funded by the CSBG. Specifically, the GAO addressed the Reagan administration's position that:

(1) The type of programs operated under CSBG duplicated social service programs under the SSBG,

(2) CAA's can find other Federal and State funds to cover administrative activities, and

(3) Funding under CSBG is not essential to the continued operation of CAA's. The report found that, in general, CSBG-funded services often were short-term and did not duplicate those provided under SSBG. Primarily, CSBG funds are used to provide services that fulfill unmet local needs and to complement those services provided by other agencies. Unmet local needs cited by GAO include temporary housing, transportation, and services for the elderly. CSBG-funded agencies provided such complementary programs as the training of day care personnel for SSBG-funded day care programs and temporary shelter for clients awaiting more permanent housing financed by other sources. The most predominant CSBG-funded services found by GAO were information, outreach, and referral as well as emergency and nutritional services.

GAO also found that CSBG funds often are used for administration of other social service programs which may have limitations on the use of their own funds for administrative expenses. Consequently, CAA's are not in a position to find other Federal and State funds to cover administrative costs. According to GAO, the Federal Government in 1984 provided 89 percent of the total funds received by CAA's in 32 States. The remaining 11 percent of the 1984 budgets of reporting CAA's were provided by non-Federal funds. Several other Federal programs, including Head Start, the Community Development Block Grant, and Low Income Home Energy Assistance, provide substantial CAA funding.

The GAO report also did not support the administration's claims that CSBG funding is nonessential to continued program operation. State and local governments are under such fiscal duress that they may not be able to replace lost CSBG funds.

The administration attempted to terminate the CSBG in fiscal years 1985, 1986, and 1987, requesting funding only to cover costs of phasing out the program. Congress, however, has resisted the administration's proposal and has continued to support funding for the CSBG. For fiscal year 1988, the administration requested $310 million for the operation of the CSBG program.

(B) ELDERLY SHARE OF SERVICES

The role that the Social Services Block Grant plays in providing services to the elderly had been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for groups such as the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

Under title XX, the extent of program participation on the part of the elderly was difficult to determine because programs were not age specific. States had a great deal of flexibility in reporting under the program, and, as a result, it was difficult to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under SSBG has made efforts to track services to the elderly even more difficult. States are required to file yearly pre-expenditure reports, but these do not adhere to a standardized format and are of limited value in determining the impact of program and funding changes on specific populations.

The American Association of Retired Persons conducted a telephone survey in 1987 to determine the amount of SSBG funds being used for services to the elderly. The survey showed that 47 States use some portion of their SSBG funds to provide services to older persons. Forty-four of the States submitted estimates on the amount provided, running from less than 1 percent up to 50 percent, with an average of 18 percent. Most States indicated that they have held service levels relatively constant by a variety of devices including appropriating their own funds, cutting staff, transferring programs to other funding sources, requiring local matching funds or reducing the frequency of services to an individual. The most frequently provided services were home-based, adult protective, adult day care, transportation, and nutrition services. At the same time the areas of unmet need were home-based, adult protective, transportation, and respite services. The majority of States characterized their services as preventive, that is, attempts to maintain the independence of older people in the community. The survey also found that while the level of SSBG funding of services to older persons appears to have held steady or declined only slightly, there nevertheless has been a large decline in the numbers of older persons assisted. This is partially due to focusing on very-low-income persons. This finding is supported by a 1986 Urban Institute report that found that the lowering of income eligibility levels may have reduced the availability of in-home services to older persons.

It seems clear that while funding for the SSBG has remained relatively constant, there is a strong potential for fierce competition among competing recipient groups. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interests of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources. A voluntary survey conducted by the American Public Welfare Association found that in 21 States, people age 60 and older made up 15 percent of SSBG recipients in fiscal year 1983. Comparing 12 of these States with data from the same States in fiscal year 1982, the survey found that the percentage of elderly recipients in these States dropped from 19.1 percent in fiscal year 1982 to 14.7 percent in fiscal year 1983. At the same time, the number of children recipients rose from 38.8 percent in fiscal year 1982 to 46.4 percent in fiscal year 1983.

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant also remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of CSBG funds.

A 1985 study by the National Association of State Community Services programs on State use of fiscal year 1985 CSBG funds provides some interesting clues. Although the survey was voluntary, all jurisdictions eligible for CSBG allotments answered all or part of the survey. Thus, the National Association of State Community Services programs received data on CSBG expenditures broken down by program category and number of persons served which provides an indication of the impact of CSBG services on the elderly (see table 1). For example, expenditures for employment services, which includes job training and referral services for the elderly, accounted for almost 12 percent of total expenditures and served over 1 million persons. Housing programs, in fiscal year 1985, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, also served over 1 million persons, many of whom are elderly. A catchall program category supports a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, and information and referrals or linkages with other programs. Emergency services such as donations of clothing, food and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds. Combined, these two program categories reached more than 17 million needy persons in 1985. Unfortunately, data related to the age, sex, race, and income levels of program participants were not reported in the survey. Until such data are available, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

TABLE 1.—FISCAL 1985 CSBG EXPENDITURES AND PERSONS SERVED IN 40 STATES BY PROGRAM CATEGORY

Program category	FY 1985 CSBG funds spent	Percent [1]	Persons assisted [2]
Employment	27,738,353	12	1,003,187
Education	22,222,070	9	2,141,575
Income management	17,372,877	7	3,926,750
Housing	19,213,736	8	1,014,078
Emergency services	45,997,496	20	5,831,412
Nutrition	35,961,954	15	26,418,077
Linkages	64,913,228	28	11,685,810

[1] Figures do not total to 100% due to rounding.

[2] Numbers for persons assisted do not total because an unestimated amount of duplication exists in each category.

Note.—The FY85 CSBG funds allocated to these 40 States represent 69.91 percent of all Federal CSBG funds made available to States and territories in fiscal year 1985.

Source: National Association of the State Community Services Programs A(NASCSP). Center for Community Futures. Statistical Report on the Community Services Block Grant for 1985. p. E–4.

3. LEGISLATION

(A) SOCIAL SERVICES BLOCK GRANT APPROPRIATIONS

The 1981 Budget Reconciliation Act fixed authorization levels 20 percent below those in fiscal year 1981, with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

For fiscal year 1986, President Reagan requested that the full entitlement level of $2.7 billion be appropriated for the SSBG, and Congress again appropriated that amount. However, under the Gramm-Rudman-Hollings deficit-reduction procedures, $116 million was lost through automatic sequestration. Although the Supreme Court invalidated the process, Congress upheld the budget cuts in March 1986 with Public Law 99-366.

The President requested $2.7 billion for the SSBG for fiscal years 1987 and 1988, as well. Congress incorporated the $2.7 billion into a governmentwide continuing appropriations resolution for fiscal year 1987 (Public Law 99-500) and appropriated a one-time $50 million increase for fiscal year 1988 for a total of $2.75 billion (Public Law 100-202). The additional funds must be used for additional services and may not supplant existing State social services funds.

(B) COMMUNITY SERVICES BLOCK GRANT REAUTHORIZATION AND APPROPRIATIONS

As established in the 1981 Omnibus Budget Reconciliation Act, the Community Services Block Grant (CSBG) was scheduled to expire at the end of fiscal year 1986. The Human Services Reauthorization Act of 1986 (Public Law 99-425) has since extended the CSBG Act through fiscal year 1990 at the following levels: $390 million for fiscal year 1987, $409.5 million for fiscal year 1988, $430 million for fiscal year 1989, and $451.5 million for 1990. Of the total appropriated each year, the Secretary of the Department of Health and Human Services is authorized to reserve up to 9 percent for discretionary use. The remaining funds are allotted to States in the same proportion as the amounts that the States received in fiscal 1981 from CSA.

The act also authorizes $3 million annually through fiscal year 1990 for the Community Food and Nutrition Program, and authorizes an additional $5 million annually, through fiscal year 1989, for a demonstration program of innovative antipoverty approaches.

As a result of the Gramm-Rudman-Hollings deficit reduction legislation, the $370.3 million that Congress appropriated for fiscal year 1986 was reduced to $354.4 million. Although the Supreme court invalidated the automatic sequestration process, Congress upheld the reduction through enactment of Public Law 99-366 in March 1986.

The administration has submitted similar budget requests for the CSBG for several years. It hoped to phase out the CSBG during fiscal year 1986 and eliminate it entirely by fiscal year 1987. Only

$3.6 million was requested for fiscal year 1987 to cover Federal administrative expenses related to the phasing out of the program. However, Congress rejected the administration's proposal and appropriated $369.9 million for the CSBG in fiscal year 1987 plus $2.5 million for the Community Food and Nutrition Program.

One of the administration's primary contentions was that the CSBG program duplicates other Federal activities and is non-essential. This, however, runs contrary to the 1986 GAO report mentioned earlier. CSBG funds often are used to fill specific unmet needs or to pay for services not eligible for funding under the CSBG.

In an apparent reversal, the administration has requested $310 million for the CSBG program for fiscal year 1988; Congress has appropriated $382.2 million.

B. HOMELESS SERVICES

1. Issues

(A) NEED

Over the past few years, the plight of the Nation's homeless and hungry has attracted a great deal of concern and publicity. Although reliable statistics are hard to find, it is clear that a large number of Americans are homeless. The Department of Housing and Urban Development (HUD) unleashed a storm of controversy with a 1984 report that concluded that there were only 250,000 to 350,000 homeless persons nationwide. Other groups that work with the homeless insist that the total is about 10 times that amount.

A study completed in 1986 by the National Bureau of Economic Research (NBER) upheld the conclusion of the HUD study. The NBER study also concluded, however, that the homeless population increased by 23 to 30 percent from 1983 to 1985. While questions may be raised concerning the methodology of the report—findings are based on an extrapolation of an estimate for New York City only—comparative data to verify or challenge the NBER study are not readily available.

While no one knows precisely how many Americans are going hungry or are malnourished, institutions involved in providing emergency food assistance have seen dramatic increases in the numbers of people seeking assistance during the past few years. According to a report released in 1987 by the U.S. Conference of Mayors of a survey of city officials in 26 major cities, requests for emergency shelter in 1987 rose by an average of 21 percent from 1986. Requests for food rose by an average of 18 percent.

A 1986 report by the Partnership for the Homeless found that homelessness in the winter of 1985 increased by 16 percent from the winter of 1984 while the number of homeless who could not be provided shelter increased by almost 13 percent. The report also found that the number of homeless families with children continued to increase more rapidly than the number of single adults and youths, and that most of the Nation's major cities had not planned to cushion the impact of expected Federal budget cuts in program for the homeless.

Homelessness stems from a variety of factors, including unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, personal crises, substance abuse, and housing shortfalls in urban areas. The deinstitutionalized chronically mentally ill comprise the largest portion of the homeless, between one-fourth and one-third of the total. According to the administration's Interagency Task Force on Food and Shelter for the Homeless, the number of patients in mental hospitals dropped from 560,000 in the mid-1950's to 100,000–150,000 in the early 1980's. In some cities, veterans of Vietnam or earlier conflicts are thought to make up one-third to one-half of the homeless. The fastest growing segment among the homeless, however, is unemployed individuals and their families. The 1987 U.S. Conference of Mayors report states that families demanding shelter increased by 32 percent in the past year and represented one-third of the homeless in the cities surveyed. Forty-four percent of the homeless are minorities. Recent studies also have documented a new dimension—the suburban homeless. In some relatively affluent suburban communities with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses, and instead, are living on the streets, in publicly funded shelters, or in their automobiles.

A 1987 report by the National Coalition for the Homeless estimates that 15–20 percent of the homeless are over age 60. For those elderly who are homeless, a great deal of the problem results from the lack of health care and affordable housing due to skyrocketing rents, elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. The Reagan administration has, for example, stopped new construction of low-income housing while cutting annual Federal subsidies. In the meantime, the number of people on waiting lists for low-income public housing has grown.

For the mentally disabled, the policy of deinstitutionalization has led to the emptying of State hospitals. However, with no intermediate community services other than community mental health centers, many of these centers are underfunded, uncoordinated, and do not adequately address the shelter needs of the chronically mentally ill. Unfortunately, the homeless who are suffering from significant physical and mental health problems must negotiate their way through a fragmented, complicated, and often hostile system of income, housing, health, and social service agencies and programs.

(B) SERVICES

Private and public resources have been mobilized to attempt to meet the immediate needs for food and shelter. Shelters and other facilities available to the homeless generally are provided by private groups, sometimes with financial help from local governments. In addition to emergency shelters, some localities provide families or individuals with certificates or vouchers to help pay the rent. Vouchers may also be given to destitute people to enable them to rent rooms in single-room occupancy buildings or hotels.

Something of a new frontier in the law recently has begun to develop in the realm of rights of homeless individuals. In the face of housing shortages, homeless people are increasingly turning to the courts for assistance, and judges have started to define their rights. While the Constitution does not explicitly guarantee a right to shelter, judges have ordered State and local officials to provide shelter based on State constitutions and statutes and on provisions in the Federal laws. It can be expected that advocates for the politically powerless homeless will continue to use the courts to obtain and to enforce the basic rights and benefits of the homeless.

One experimental project initiated in 1987 to reach the homeless elderly is being conducted by the Indiana Department of Aging with Older Americans Act funds. Three area agencies on aging are working with older persons who are homeless or marginally housed in an attempt to find long-term solutions to the housing problems of those persons through employment. An enrolled person receives assessment of employment needs and skills, individual counseling, job-readiness training, peer group support through job clubs, wages for work experience, and skills training through existing programs such as the Job Training Partnership Act and Community Services Block Grant programs.

In Boston, a group of concerned citizens have formed the Elderly Homeless Coalition, and developed a plan to provide rooms and meals, health, mental health, and case management services for the city's homeless elderly.

The Emergency Food and Shelter program, currently administered by the Federal Emergency Management Agency [FEMA], has provided more than $400 million for food, shelter, and other forms of assistance to the homeless. The program was initiated in the Emergency Jobs Appropriations Act approved in 1983 (Public Law 98–8), and has continued through appropriations, supplemental appropriations, and a continuing resolution in subsequent years. Originally, funds for the program were disbursed through two channels. One was through a national board composed of representatives from six charitable organizations and from FEMA itself. The other was through the States to whom FEMA was authorized to distribute $50 million for distribution to local distributors and service agencies. The State channel subsequently was eliminated.

Delays in the State channel were likely the cause of its elimination. In an evaluation of the shelter program in 1985, the Urban Institute noted that delays in the State channel resulted from a lack of State authorizing legislation, State requirements for written regulations, State requirements for proposal and assessment processes, obligations without distribution, and time lags because of State coordination requirements. The study also mentioned the speed and flexibility with which the National Board and the nonprofit sector were able to get money for emergency food and shelter to the local communities.

By most accounts, the FEMA program, which has utilized local programs rather than duplicating their efforts, has worked well. In 1987, the FEMA program funded about 98.5 million meals at a cost of $70 million. A meal provided from these funds is estimated to cost approximately 71 cents and the estimated cost of a night in a shelter is $2.24.

Hundreds of citizens also have voluntarily donated time and money to help feed the hungry and house the homeless. But even with these efforts, optimistic statistics show that only one in three homeless individuals had a bed and a bowl of soup in a public or private shelter in the winter of 1987. Other figures suggest that only 1 of 20 were so fortunate. Both figures illustrate how much has yet to be done. The HUD report, for example, states that in 1984 there were about 111,000 shelter spaces available nationwide for as many as 350,000 homeless, indicating a serious shortage. Moreover, these shelters are at risk in many communities because of neighborhood opposition, inner-city redevelopment, and other factors. More recently, the U.S. Conference of Mayors reported that in two-thirds of the 26 cities they surveyed, homeless people "routinely" are turned away from overcrowded shelters and the demand for emergency food frequently goes unmet.

(C) FEDERAL ROLE

Most would agree that homelessness is a problem deserving the attention of policymakers. However, the administration has contended that homelessness is a local problem and maintains that the Federal role should be limited to making available to the homeless, surplus resources, such as food and buildings. In his fiscal year 1986 budget request, President Reagan proposed continuing the Interagency Task Force on Food and Shelter for the Homeless, which coordinates administration efforts to aid the homeless. The fiscal year 1987 budget request, however, did not contain a reference to the Task Force. As in previous years, the administration wanted to eliminate the program of the Federal Emergency Management Agency that has provided emergency funding for food and shelter for the homeless since 1983. The President also called for cutting block grants for community services and development that have been used by some States and localities to provide food and shelter to homeless individuals. In addition, the administration wanted to eliminate the Temporary Emergency Food Assistance Program within the Department of Agriculture.

Those who support the administration's position question whether the Federal Government should take on new functions that traditionally have been under the purview of voluntary organizations and local governments. While recognizing a need for more Federal resources to aid the homeless, there is concern that Federal legislative initiatives will elevate discretionary choices traditionally made at the State and community levels to the Federal level. They maintain that State and local governments are better suited to gauge their communities' needs and believe that Federal intervention will become institutional. Unfortunately, a recent poll shows that about half of all adult Americans think local governments are not demonstrating enough concern for the homeless.

Others argue that the problem is so acute that major Federal intervention is needed. However, even with substantial Federal emergency funding, supporters of more Federal involvement contend that primary decisionmaking still will reside at the community level.

Yet another facet of the problem is how much relief can result from Government efforts and how far governments should go. Even with an abundant availability of services, an unknown portion of the population may be reluctant to accept them, raising basic questions about what can be done to impose services on them. A subtle indication of this has emerged in a few major cities which have or are considering new ordinances to temporarily detain mentally ill homeless or others refusing to accept shelter from the elements. And since so much of the problem is thought to involve the chronically mentally ill, questions have been raised about whether more control can be exerted over patient releases and long-term institutionalization.

2. Legislation

Many homeless persons qualify for public assistance, but may be unaware of the programs, lack the skills to obtain benefits, or are unable to apply because they have no address. Some, for example, qualify for Supplemental Security Income which provides aid to the needy blind, disabled, and elderly. Others may qualify for benefits such as food stamps and veterans benefits. In the 99th Congress, statutes governing various welfare programs were amended to provide for the needs of the homeless through provisions included in the Homeless Eligibility Clarification Act (Title XI of the Anti-Drug Abuse Act of 1986, Public Law 99-570). Among the new provisions were removal of restrictions limiting food stamp eligibility of homeless persons living in shelters, Supplemental Security Income payments to eligible homeless persons, and establishment of methods of delivering veterans' benefits to persons lacking a mailing address.

Legislative efforts to expand assistance to the homeless were among the first items on the agenda of the 100th Congress. Most Members of Congress believe that solutions to the problem of homelessness should be developed at the local level. Unlike the administration, however, Congress felt that the Federal Government had an important role to play in the solution to the homeless problem. In January 1987, Congress passed a measure reallocating $50 million in disaster relief funds to programs aiding the homeless (Public Law 100-6).

The House followed up with a much larger aid bill, H.R. 558, bringing together new funding and other changes reported from the House Agriculture, Banking, and Energy and Commerce Committees. The Senate followed suit, passing its own version, consolidating measures from the Agriculture, Banking and Housing, Labor and Human Resources, Governmental Affairs, and Veterans Affairs Committees. Initially, the administration criticized the bills for their high cost and seemingly duplicative programs, but never threatened to veto the final bill. House and Senate conferees resolved the differences in their respective versions of the aid package and the Stewart B. McKinney Homeless Assistance Act, was signed into law on July 22, 1987 (Public Law 100-77). In parallel action, congressional conferees for the fiscal year 1987 supplemental appropriations bill, H.R. 1827, agreed to appropriate most of the funds for the programs included in the conference version of H.R.

558 prior to its enactment, and the measure also was signed into law in July (Public Law 100-71).

Most of the fiscal year 1987 appropriated funds are available for expenditure through fiscal year 1988. See table 2 for the authorizations and appropriations for homeless services provided under various Federal agencies and departments.

Following is a summary of the newly authorized provisions under various programs contained in the Stewart B. McKinney Homeless Assistance Act:

Federal Emergency Management Agency:

Authorizes an additional $15 million for fiscal year 1987 ($10 million of which was appropriated) for a total of $125 million and $124 million for fiscal year 1988 for the emergency food and shelter program.

Department of Housing and Urban Development:

(1) Emergency Shelter Grants Program (title IV-B) authorizes grants to States, local governments, and private nonprofit organizations providing assistance to homeless individuals according to the community development block grant program formula. Eligible activities include renovating or converting buildings for use as emergency shelters, providing essential services concerned with employment, health, drug abuse, or education (if not provided by local government and not to exceed 15 percent of assistance), and covering the cost of maintenance, insurance, utilities, and furnishings. Each grantee is required to match the grant with funds from other sources.

(2) Supportive Housing Demonstration Program (title IV-C) authorizes financial and technical assistance to States, local governments, and private nonprofit organizations for the provision of transitional housing and supportive services for the homeless, including permanent housing for homeless handicapped persons who are capable of moving into independent living.

(3) Supplemental Assistance for Facilities to Assist the Homeless (title IV-D) authorizes awards to States, cities, urban counties, tribes, or private nonprofit organizations to cover costs in excess of assistance provided under the emergency shelter grant or the supportive housing demonstration programs or provide comprehensive assistance for particularly innovative programs or alternative methods of meeting needs. To the extent practical, at least 50 percent of the funds are to support projects which primarily benefit homeless elderly individuals and homeless families with children.

(4) Assistance for Single Room Occupancy Dwellings (title IV-E) authorizes competitive awards for the rehabilitation of single-room occupancy units to be used solely to house the homeless.

(5) Identification and Use of Surplus Federal Property (title V) authorizes HUD to locate underutilized Federal property that might be converted into housing for homeless individuals and authorizes the General Services Administration and Department of Health and Human Services to make the buildings available to States, local governments, and nonprofit agencies.

Department of Health and Human Services:

(1) Health Services for the Homeless (title VI–A) authorizes grants through the Health Resources and Services Administration to public and nonprofit private entities for delivery of outpatient primary health services and substance abuse services to homeless individuals.

(2) Community Mental Health Services for the Homeless (title VI–B) authorizes a block grant to the States to provide outpatient mental health services to homeless people who are chronically mentally ill.

(3) Community Mental Health Demonstration Projects for Homeless Individuals who are Chronically Mentally Ill (title VI–B) authorizes demonstration grants to State, local governments, and private nonprofit organizations to provide community-based mental health services to homeless individuals who are chronically mentally ill.

(4) Community Demonstration Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals (title VI–B) authorizes grants, contracts, and cooperative agreements to develop and expand alcohol and drug abuse treatment services for homeless individuals. At least 1.5 percent of the appropriated amount is to be allocated to Indian tribes.

(5) Emergency Community Services Homeless Grant Program (title VII–D) authorizes additional community service block grant funds to be allocated to States according to the same formula set forth in the Community Service Block Grant Act.

(6) Study of Homeless Youth (title VII–E) is authorized to be awarded by the Secretary for a recipient to research the underlying causes of youth homelessness.

Department of Education:

(1) Adult Education for the Homeless (title VII–A) authorizes a program of "Statewide Literacy Initiatives" for grants to the States to develop a plan and implement a program of literacy training and basic skills remediation.

(2) Education for Homeless Children and Youth (title VII–B) authorizes State grants to establish an Office of Coordinator of Education on Homeless Children and Youth in each State to assure that homeless children have access to public education.

Department of Labor:

(1) Job Training for the Homeless (title VII–C) authorizes job training demonstration grants for the homeless.

(2) Homeless Veterans Reintegration Projects (title VII–C) authorizes grants to expedite the reintegration of homeless veterans into the labor force.

Department of Agriculture:

(1) The Food Stamp Program is an ongoing program. Changes in the program will allow individuals to use their food stamps to purchase meals served by public or private nonprofit establishments that feed homeless persons, authorizes State outreach programs to inform the homeless about food stamps, requires "expedited service" for the homeless, and allows related families with children who live together to be treated as separate households for the purpose of obtaining food stamps.

(2) The Temporary Emergency Food Assistance Program is extended through fiscal year 1988. The program allocates federally donated foods and some administrative funding to the States.

In addition, the new law authorizes $200,000 for fiscal year 1987 and $2.5 million for fiscal year 1988 to establish a 3 year Interagency Council on the Homeless, composed of most Cabinet Secretaries and the heads of several independent agencies.

TABLE 2.—FUNDING LEVELS FOR MAJOR PROGRAMS BENEFITING THE HOMELESS

Department or agency	FY 1987 authorization [1]	Final FY 1987 appropriation [2]	FY 1988 authorization [1]	Final FY 1988 appropriation [3]
FEMA:				
Emergency food & shelter	[4] $130,000,000	$125,000,000	[5] $124,000,000	$114,000,000
HUD:				
Emergency shelter	100,000,000	60,000,000	120,000,000	8,000,000
Supportive housing	[6] 85,000,000	[6] 85,000,000	100,000,000	65,000,000
Supplemental assistance	25,000,000	15,000,000	25,000,000	0
Single room occupancy assist.	35,000,000	35,000,000	35,000,000	0
DHHS:				
Community health services	50,000,000	46,000,000	30,000,000	14,361,000
Comm. mental health blk. gt.	35,000,000	32,200,000	(7)	11,489,000
Mental health demonstration	10,000,000	9,300,000	0	0
Alcohol & drug abuse demo.	10,000,000	9,200,000	0	0
Comm. services block grant	40,000,000	36,800,000	40,000,000	19,148,000
EDUCATION:				
Adult education	7,500,000	6,900,000	10,000,000	[8] 7,180,000
Youth & children education	5,000,000	4,600,000	5,000,000	4,787,000
Information & dissemination	0	0	2,500,000	....
LABOR:				
Job training	0	0	10,000,000	[9] 7,659,000
Veteran's reintegration	0	0	2,000,000	[9] 1,915,000
AGRICULTURE:				
Temp. emergency food assist.	50,000,000	50,000,000	50,000,000	0
VETERANS:				
Chronically mentally ill	[10] 10,000,000	[10] 10,000,000	0	0
Domicialiary care	[11] 15,000,000	15,000,000	0	0

[1] Unless otherwise noted, P.L. 100–77, the Stewart McKinney Act, is the authorizing law for both FY87 and FY88.

[2] Unless otherwise noted, P.L. 100–71, the Supplemental Appropriations Act for FY87, is the appropriations law for FY87. P.L. 100–71 stated that for Urgent Relief for the Homeless, unexpended FY87 could be carried over into FY88.

[3] P.L. 100–202, the Continuing Resolution for FY88, is the appropriations law for FY88. For reference see: H.R. 2783, the Department of Housing and Urban Development and Independent Agencies Appropriations Bill of 1988; H.R. 3058, the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations of 1988; and, the conference report on H.J. Res. 395.

[4] The authority originates as follows: $70 million in P.L. 99–591, an FY87 continuing resolution; $45 million in P.L. 100–6 as a transfer of funds from the FEMA disaster relief account; and $15 million in P.L. 100–77.

[5] P.L. 99–591 appropriated $10 million.

[6] This is broken down as $5 million made available by P.L. 99–591, and $80 million authorized by P.L. 100–77 and appropriated by P.L. 100–71.

[7] Such funds as may be necessary.

[8] The conference report on H.J. Res. 395 indicated $124,462,000 was appropriated for adult education which included funds for the Homeless Adult Education program. The Department of Education proposed to the House and Senate Appropriations Committees that $7,180,000 be earmarked for Homeless Adult Education. Telephone conversations with Tom Jones and Marilyn Hall, Department of Education, Jan. 22, 1988.

[9] The budget tables in conference report on H.J. Res. 395 indicated a total of $9,574,000 for job training; however, the statement of managers clarified that $1,915,000 of this sum is for Veterans' Reintegration (Congressional Record, Dec. 21, 1987, H12468).

[10] This is broken down as $5 million authorized to be transferred from FEMA disaster relief funds by P.L. 100–6, and an additional $5 million authorized and appropriated by P.L. 100–71.

[11] Authority and appropriations made available by P.L. 100–71.

C. EDUCATION

1. Background

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, and higher education, as well as continuing education programs that benefit students of all ages. The role of the Federal Government in education has been to ensure equal educational opportunity, to enhance the quality of education, and to address national priorities in training.

Federal and State interest in developing educational opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a list of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit older people. The White Houe Conference on Aging report noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons and assure a match between the needs of older adults and the training of those who serve them.

While many strong arguments exist for the importance of formal and informal education opportunities for older persons, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily at the establishment and maintenance of programs for children and youth, including those of the traditional college ages. This is due largely to the perception of education as a foundation constructed in the early stages of human development.

While formal education is viewed as a finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that a need exists for learning beyond the informal environment for the elderly. This need for structured learning may appeal to "returning students" who have not completed their formal education, older workers who require retraining in skills adaptable to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education to the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs generally have lagged, private and public-based education programs have emerged recently that are designed to better meet the growing educational needs of older persons.

2. Issues

(A) ADULT LITERACY

Conventional literacy means the ability to read and write. The Census Bureau estimated that the Nation's conventional illiteracy rate was 0.5 percent in 1980, which would place the estimated number at over 1 million. However, literacy means more than just the ability to read and write. The term "functional illiteracy" began to be used during the 1940's and 1950's to describe persons who were incapable of understanding written instructions necessary to accomplish specific tasks or functions.

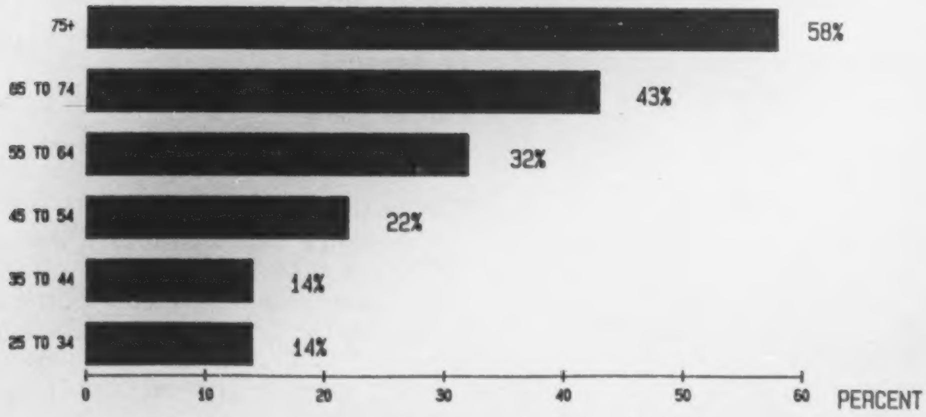
Definitions of functional literacy depend on the specific tasks, skills, or objectives thought necessary for the comprehension of a literate person. As various experts defined clusters of needed skills, definitions proliferated. These definitions became more complex as the technological and information needs of the society increased. Thus, despite apparent consensus that some measure of functional illiteracy must replace the conventional definition, no agreement has been reached on a definition. Without a standard definition and widely accepted measure of illiteracy, it is difficult to determine the extent of illiteracy in the country and whether it is increasing or decreasing.

However, the results of some studies have revealed cause for concern. In a 1986 study of illiteracy by the National Advisory Council on Adult Education, an estimated 40 percent of armed services enlistees were found to read below the 9th grade level. An estimated two-thirds of the Nation's colleges find it necessary to provide remedial reading and writing courses. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol and drug abuse—the social consequences of widespread illiteracy in this country are disturbing.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. According to 1982 census data, nearly one-third of all illiterate adults are age 60 and over. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the groups of adults 25 years and over with less than a high school education.

CHART 1

PERCENT OF AGE GROUPS WITH LESS THAN 12 YEARS OF EDUCATION: 1987



Source: 1987 Current Population Survey

Generally, the higher educational system in the United States has failed to address the needs of the older, illiterate adult. Although adult education programs exist throughout the country, only 2.8 million participated in the programs in 1987. Of those, only 185,643 were age 60 or older. It has been suggested that Federal education programs to meet specific categorical objectives have been responsible, in part, for the failure to prevent adult illiteracy. Advocates the block grant approach toward social services funding, including the Reagan administration, have suggested that this approach would reduce administrative costs and increase overall coverage and flexibility in literacy initiatives. However, specific targeting requirements and regulations would need to be an integral of any program consolidation. Recent evidence indicates that adult education funds otherwise would be used to serve persons who require less extensive literacy training. In other words, the reduced payments which often accompany block grant funding could prove to be an incentive for States to allocate their scarce dollars to those persons who require less resources to train—those with better jobs, more education, and higher incomes. The ambiguity surrounding the block grant approach makes any comprehensive reordering of literacy priorities difficult to resolve.

The first significant Federal adult literacy programs began in the military services. Programs for civilians started with the Manpower Development and Training Act of 1964, providing job training for the unemployed. Many participants were found to be functionally illiterate and the program was amended to provide basic educational skills. The Economic Opportunity Act of 1964 provided the first State grants for persons needing basic literacy skills. The Adult Education Act was enacted as part of the Elementary and Secondary Education Amendments of 1966 (Public Law 89-750). The act has been amended several times since 1966, but the basic purpose and structure have remained similar since then.

During its first term, the Reagan administration requested a one-third reduction of Federal funds for the Adult Education Act, with the ultimate intent of turning over such programs to the States under the "Federalism Initiative." In response to the President's Commission on Excellence in Education report, the Reagan administration made the elimination of illiteracy a major focus. The Adult Literacy Initiative was launched in the Department of Education on September 7, 1983. According to the statement by former Secretary of Education Terrell H. Bell, the program is designed "to increase national attention to the promotion of adult literacy and to enhance existing literacy programs." It is not a legislatively mandated program, but is based on various discretionary authorities available to the Secretary of Education.

The program's operations include:

(1) Cooperating with the Coalition for Literacy and the Advertising Council in sponsoring a National Awareness Campaign on adult literacy, including a toll-free "Literacy Hotline,"

(2) Redirecting part of the College Work-Study Program to employ students in literacy programs,

(3) Encouraging student and adult volunteers as literacy tutors,

(4) Working with the Federal Employee Literacy Training program, whereby all Federal agencies are encouraging employees to volunteer as literacy tutors,

(5) Sponsoring national meetings and conferences, and

(6) Developing private/public sector partnerships, including support for the Business Council for Effective Literacy.

The Department of Education's Office of Educational Research and Improvement sponsored the National Adult Literacy Project, which issued research reports in 1985 on a number of topics, including history and description of adult basic education programs, literacy and employment, an agenda for literacy research and development, support systems for adult education, literacy and television, alternative strategies for adult education participation, and a guidebook on effective literacy projects.

(B) ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (AEA) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to establish adult education programs to help adults 16 years and older to acquire basic literacy skills necessary to function in society, enable adults to complete a secondary school education, and make available to adults the means to secure training and education that will enable them to become more employable, productive, and responsible citizens. Funds provided for adult education support State formula matching grants to combat functional illiteracy for adults over 16 and are distributed by a formula based on the number of adults in a State without high school diplomas who currently are not enrolled in school. The AEA serves almost 3 million participants annually.

In 1977, a major change began in adult education enrollment. The enrollment of those age 16 to 44 decreased while the enrollment of those 45 to 65 increased. A 1981 survey conducted by the National Center for Education Statistics revealed that 768,000 persons age 65 and older, or 3.1 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35, this marked the highest number and percentage of older people involved in adult education ever recorded by the National Center for Education Statistics. Even more dramatic were statistics that showed that the number of persons 65 and older participating in adult education has almost tripled, growing at the average rate of 30 percent for every 3 years compared to an average rate of 12 percent for every 3 years for adult participation of all ages.

Nevertheless, with only 3.1 percent of the elderly population enrolled in an educational institution today, older people continue to be underrepresented in education programs in relation to the percentage of the total U.S. adult population they comprise. This is due partly to the fact that while older persons certainly have the ability to learn, the desire to learn is a function of educational experience. For example, the National Center for Education Statistics reported in 1981 that the level of participation in adult education rose at each higher educational level from 2.2 percent of the total population with less than an eighth grade education to 31 percent with 5 years of college or more. Further, a 1984 Department of Education report supports this correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment and life-coping skills and gradually are shifting to educational programs on self-sufficiency. Few programs currently exist to meet the growing demand for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift their emphasis from personal interest courses to include job-training skills.

The Reagan administration had proposed consolidating Federal aid to vocational education and adult education programs into a simplified block grant to States. Concern was raised, however, that this proposal ignores fundamental differences between vocational education, which serves adults who require retraining for employment, and adult education, which acts as a basis for learning in later life, and only would weaken these successful programs. As a result, Congress consistently rejected this proposal to simplify the program and increase States' discretion, and it was not recommended by the administration in 1987.

(C) HIGHER EDUCATION

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. A recent study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and were able to identify them as peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

In response to this challenge, some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. At Smith College, for example, the Ada Comstock Scholar Program offers a traditional education to women older than undergraduates of traditional age. Older students are fully integrated into the academic and campus life, although Ada Comstock students are allowed to take as long as they need or want to complete their college requirements. The older students, in return, bring an added dimension and vitality to the classroom by sharing their broad-based life experiences and interest in learning.

For those older students who cannot afford the cost of a private college, some States are moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. Since only two States provide reimbursement to individual institutions which waive tuition payments, the participating colleges must make substantial investments in terms of curricular emphasis and financial support toward meeting the needs of older students.

(D) ELDERHOSTEL

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the belief that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most Elderhostel programs deliberately avoid age-specific focus on the problems of aging.

Since the inception of Elderhostel in New Hampshire in 1975, older adults in dramatically increasing numbers have enrolled in the programs. In 1987, more than 800 private and public colleges and educational institutions in 50 States and Canada served 142,000 summer and academic year hostelers. In addition, hostelers participated in programs in Scandinavia, France, Germany, the Netherlands, Italy, Great Britain, Israel, and Australia. Even with the burgeoning numbers of participants, however, Elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

(E) INTERGENERATIONAL PROGRAMS

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. There are now more than 100 intergenerational school programs nationwide. More than 250,000 volunteers participate in grades kindergarten through 12.

Intergenerational school programs range from informal and haphazard to large, centrally organized programs spanning several school districts. One example of a successful intergenerational program is the Teaching Learning Community, begun by an elementary art teacher in 1971 in Ann Arbor, MI. Teaching Learning Community links older persons with a small group of student-apprentices. They work together on a joint activity on a regular, weekly basis with the focus on teaching the student a new skill and creating a product while communicating with and developing respect and regard for others. The program has spread to many States, including Florida, Pennsylvania, Idaho, Texas, and New York.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children and to better cope with their own personal traumas, such as the death of a spouse or friend. These programs also allow schoolchildren to develop a more positive view of older persons while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components:

(1) Establishing an information bank of intergenerational programs across the country,

(2) Disseminating this information to organizations interested in establishing such programs,

(3) Working with professional organizations to stimulate interest, and

(4) Funding intergenerational demonstration projects.

3. LEGISLATION

The Older Americans Act (OAA) Amendments of 1987 (Public Law 100-175) include a new provision which requires area agencies on aging to conduct a survey on the availability of tuition-free postsecondary education in their area, supplement the data where necessary, and disseminate this information through senior centers, congregate nutrition sites, and other appropriate locations. It is anticipated that access to such information will increase the enrollment of older persons in higher education programs.

The OAA amendments also include a provision that allows the Commissioner on Aging to award demonstration grants, providing expanded, innovative volunteer opportunities to older persons which are designed to fulfill unmet community needs. These projects may include intergenerational services by older persons to meet the needs of children in day care and school settings.

In addition to the provisions in the Older Americans Act amendments, the 100th Congress has been acting on several measures related to the Adult Education Act and other literacy programs.

The Stewart B. McKinney Homeless Assistance Act (Public Law 100-77) authorizes an Adult Education for the Homeless program of statewide literacy initiatives for grants to States to develop and implement a program of literacy training and basic skills remediation. The States, in turn, coordinate these programs with community-based organizations, VISTA recipients, adult basic education program recipients, and nonprofit literacy-action groups. Funds are allocated according to each State's homeless population, with each State receiving at least $75,000. The Act authorizes $7.5 million for fiscal year 1987 and $10 million for fiscal year 1988. A total of $6.9 million was appropriated for fiscal year 1987 in the Supplemental Appropriations Act (Public Law 100-71).

Section 701 of the Stewart McKinney Act also amends the Adult Education Act to include homeless individuals as a category in the research and demonstration program.

The fiscal year 1988 appropriations bills for the Departments of Labor, Health and Human Services, and Education, and related agencies are included in the continuing appropriations bill, Public Law 100-202. The AEA and homeless adult literacy programs received a combined appropriation of $124.5 million for fiscal year 1988. The appropriation for Library Services and Construction Act literacy programs is $4.8 million. The administration had requested $130 million for AEA programs and zero funding for LSCA literacy programs with the intent of terminating those programs.

In other legislative action during 1987, H.R. 3, the Trade and International Economic Policy Reform Act of 1987 was introduced in the House on January 6, 1987. A similar bill, S. 1420, the Omnibus Trade and Competitiveness Act, was introduced in the Senate on June 24, 1987. The House version contains 13 chapters related to education; the Senate version includes 10 education titles. Existing programs are amended, and new programs are authorized, that relate to the productivity of the work force and trade competitiveness of the Nation. Both Houses have passed their bills and the omnibus trade competitiveness bill at printing of this report awaits conference action. Among the vocational, postsecondary, and adult education provisions, the House version amends the AEA to authorize Workplace Literacy Partnerships Grants and English Literacy Grants, creates a Federal Literacy Coordination Office, directs the National Diffusion Network to disseminate literacy skills information, establishes technological literacy programs, and amends the Job Training Partnership Act (JPTA) to authorize basic and remedial education literacy training and English training for non-English speaking persons. The Senate version of H.R. 3 amends the AEA to provide literacy training programs for unemployed or underemployed persons, displaced workers, and illiterate persons; and authorizes a literacy corps, workplace literacy assistance and technological literacy programs with a priority for older adults over age 55.

H.R. 5, the School Improvement Act of 1987, amends and extends the AEA through fiscal year 1993 and authorizes an "even start" program for adult literacy for parents and their children. The reported bill has passed both the House and the Senate and is awaiting a conference in the second session of the 100th Congress. The Senate version would provide funding for adult education at correctional institutions, authorize literacy programs as part of the chapter 2 education block grant, and authorize workplace literacy partnership grants, programs for persons with limited English proficiency, programs for dropout prevention, and an "even start" program.

D. ACTION PROGRAMS

1. Background

ACTION was established in 1971 through a Presidential reorganization plan that brought together under one independent agency several existing volunteer programs. The programs transferred to ACTION in 1971 include Volunteers in Service to America (VISTA) and the National Student Volunteer Program, both previously administered by the Office of Economic Opportunity, and the Foster Grandparent Program (FGP) and Retired Senior Volunteer Program (RSVP), which had been administered by the Administration on Aging.

ACTION was given statutory authority under the Domestic Volunteer Service Act of 1973. This act also repealed prior legislative authority for ACTION's domestic programs, which had been authorized under several different acts, and reauthorized them under a single authority.

Today, programs administered by ACTION include the title I-A VISTA program, the title I-B service learning programs, the title I-C special volunteer programs, and the title II Older American Volunteer Programs (FGP, RSVP, and the Senior Companion Program). Generally, ACTION programs are directed toward reducing poverty and poverty related problems, helping the physically and mentally disabled, and assisting in a variety of other community service activities. ACTION also supports demonstration projects for testing new initiatives in voluntarism, and advocates and promotes voluntarism in the public and private sectors.

2. OLDER AMERICAN VOLUNTEER PROGRAMS

The Older American Volunteer Program (OAVP), which includes the RSVP, the FGP, and the Senior Companion Program (SCP), is the largest of the ACTION program components. For fiscal year 1987, OAVP funding constituted 68 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 and older to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies that recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local resources. According to ACTION estimates, State funding to support ACTION-funded volunteer projects is estimated at more than $19 million annually—$10 million for the FGP, $4 million for the SCP, and $5 million for the RSVP. In the past few years, State funds to support each of the programs have exceeded the Federal requirements for matching funds. To a great extent, the fact that these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services have made them enormously popular with both Congress and the administration.

(A) RETIRED SENIOR VOLUNTEER PROGRAM

The retired Senior Volunteer Program (RSVP) was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION and in 1973 the program was incorporated under title II of the Domestic Volunteer Service Act. The program is designed to provide a variety of volunteer opportunities for persons 60 and older. In fiscal year 1987 there were approximately 383,000 RSVP volunteers who are estimated to have generated more than 71 million volunteer hours. In fiscal year 1988, it is estimated that 392,000 older presons will participate in this program.

Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, crime prevention, refugee assistance, and housing rehabilitation. Program sponsors include State and local governments, universities and colleges, community organizations, and senior service groups.

Each project is locally planned, operated, and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses incurred as a result of the volunteer activities.

(B) FOSTER GRANDPARENT PROGRAM

The FGP program originated in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, FGP was incorporated under title II of the Domestic Volunteer Service Act.

The FGP provides part-time volunteer opportunities for low-income persons 60 and older to assist them in providing supportive services to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day-care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receives an hourly stipend, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. The Domestic Volunteer Service Act exempts stipends from taxation and from being treated as wages or compensation. Foster grandparents volunteers must have an income below the higher of 125 percent of the Department of Health and Human Services poverty guidelines or 100 percent of those guidelines plus the amount each State supplements the Federal Supplemental Security Income payment. In 1986, this annual income level was $6,700 for an individual in most States and $9,050 for a two-person family. For fiscal year 1987, ACTION estimates that about 23,000 foster grandparents assisted approximately 81,900 children.

TABLE 3—ACTION'S OLDER AMERICAN VOLUNTEER PROGRAMS, FISCAL 1987

	Number of volunteers		Number of projects		Number of volunteer hours	
	Action [1] (Federal)	Non-action [1] (Non-Federal)	Action [1] (Fed)	Non-action [1] (Non-Fed)	Action [1] (Fed)	Non-action [1] (Non-Fed)
SCP	7,437	2,100	96	22	5,450	1,550
FGP	23,400	2,600	249	11	17,215	1,976
RSVP	383,000	4,000	745	5	71,355,000	745,000

[1] Source of Funding.

(C) SENIOR COMPANION PROGRAM

The Senior Companion Program (SCP) was authorized in 1973 by Public Law 93-113 and incorporated under title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 amended section 211 of the act to create a separate part C containing the authorization for the Senior Companion Program. This program is designed to provide part-time volunteer opportunities for low-income persons 60 and older to assist them in providing supportive services to vulnerable, frail older persons. The volunteers assist homebound, chronically disabled older persons to maintain independent living arrangements in their own residences. Volunteers also provide services to institutionalized older persons. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. To participate in the program, volunteers must meet the same income test as for the Foster Grandparent Program.

In the Domestic Volunteer Service Act Amendments of 1984 (Public Law 98-288), Congress authorized demonstration projects to explore ways that the successful SCP could serve the growing population of frail older persons at high risk of institutionalization. To accomplish this, SCP is authorized to recruit unpaid volunteers to train senior companions and to use senior companion volunteer leaders to assist other senior companions. Grants were awarded to 19 new SCP projects and 17 new components of existing SCP projects at the beginning of fiscal year 1986. A final evaluation is due in 1988.

In fiscal year 1987, about 9,500 SCP volunteers served in 118 projects, including 1,550 volunteers in 22 non-federally funded projects. ACTION estimates that these volunteers served about 33,350 persons.

3. Volunteers in Service to America

Volunteers in Service to America (VISTA) was authorized in 1964, conceived as a domestic peace corps for volunteers to serve full-time in projects designed to reduce poverty. Today, VISTA still holds this mandate. Volunteers 18 and older serve in community activities to reduce or eliminate poverty and poverty-related problems. Activities include assisting the handicapped, the homeless, the jobless, the hungry, and the illiterate or functionally illiterate. Other activities include addressing problems related to alcohol abuse and drug abuse, and assisting in economic development, remedial education, legal and employment counseling, and other activities that help communities and individuals become self-sufficient. Volunteers also serve on Indian reservations, in federally assisted migrant worker programs and in federally assisted institutions for the mentally ill and mentally retarded.

Volunteers are expected to work full-time for a minimum of 1 year, but they may serve for up to 5 years. To the maximum extent possible, they live among and at the economic level of the people they serve. Volunteers are reimbursed for certain travel expenses and receive a small stipend for food, lodging, and incidental expenses. They also are provided health insurance and receive a monthly stipend not to exceed $75 that is paid in a lump sum at the end of their service. At least 20 percent of the volunteers must be age 55 and older. In fiscal year 1987, 540 volunteers over the age of 55 served in VISTA and represented 21.9 percent of the VISTA corps.

4. ISSUES

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in society. Historically, voluntarism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social service agencies. More recently, volunteer service has included activities for grassroots political advocacy and community improvement programs.

In many communities, the need continues for volunteer efforts to address the problems of poverty and to utilize the skills and experiences of volunteers, notably the elderly. A central theme of the Reagan administration and a major focus of the President's Task Force on Private Sector Initiatives has been to encourage increased individual and corporate responsibility in meeting local economic and social service needs. As part of the President's New Federalism initiatives, increased emphasis has been placed on shifting funding and management responsibility for many community services from the Federal level to the State and local governments, and to the private sector. For example, the administration has proposed eliminating the community services block grant—the community action program designed to provide services which have a measurable impact on the causes of poverty—and replacing it with initiatives to encourage the development of private sector antipoverty activities. Reduced funding for the CSBG has resulted in greater reliance on volunteers rather than trained professionals to administer and implement services in the community. As this shift in Federal policy continues, greater pressure in helping to meet human needs will be directed toward the voluntary sector.

5. LEGISLATION

Authorizations of appropriations for the Domestic Volunteer Service Act were to expire at the end of fiscal year 1986. The act was reviewed during the 99th Congress and on October 27, 1986, Public Law 99-551 (H.R. 4116) was signed into law, extending the volunteer programs through 1989. (See table 4 for authorization and appropriation levels for the programs.)

TABLE 4.—ACTION PROGRAMS AUTHORIZATIONS AND APPROPRIATIONS

(Millions of dollars)

	1987 auth.	1987 approp.	1988 auth.	1988 approp.	1989 auth.
VISTA	25.0	19.0	26.0	19.8	27.0
RSVP	32.0	29.6	33.3	30.6	34.6
FGP	60.0	56.1	62.4	57.4	64.9
SCP	29.7	18.0	30.9	23.1	32.2

This legislation also amended the FGP and SCP programs to permit enrollment of non-low-income persons to serve as foster grandparents and senior companions as long as they are willing to serve without a stipend or reimbursement for expenses other than for transportation, meals, and out-of-pocket expenses, and agree to work 20 hours a week as well as comply with other program requirements. Prior law allowed only enrollment of older persons who met specific income eligibility requirements. Non-low-income, unpaid individuals may participate in the program only in communities where there are no RSVP volunteers (such volunteers do not receive stipends). The new law specifies that volunteers not receiving stipends cannot replace low-income persons who serve as volunteers with stipend. The cost of administering programs for non-stipend volunteers may be supported by funds received by the Director of ACTION as gifts, funds contributed by volunteers, or locally generated contributions in excess of the required matching share for the volunteer programs.

For fiscal year 1988, Congress appropriated $7.3 million above the administration's request for the Older American Volunteer Programs. Congressional intent is to provide across-the-board cost-of-living increases to existing projects in all regions of the country that have suffered due to reduced or static funding for volunteer support costs. In addition, Congress intends that increased funds appropriated for the SCP be used for development of new senior companion programs.

E. TRANSPORTATION

Transportation is the vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs—maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need. Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support an individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

1. BACKGROUND

Three strategies have marked the Federal Government's role in providing transportation services to the elderly:

(1) Direct provision (funding capital and operating costs for transit systems),

(2) Reimbursement for transportation costs, and

(3) Fare reduction.

In fiscal years 1981–87, the Reagan administration proposed to eliminate or substantially reduce Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems.

The major federally sponsored transportation programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services and the Department of Transportation. Under the Department of Health and Human Services, a number of programs provide specialized transportation services for the elderly, including title III of the Older Americans Act (OAA), the SSBG, the CSBG, and, to a limited extent, Medicaid, which will reimburse elderly poor for transportation costs to medical facilities. Under CSBG, more dollars (approximately 38 percent) are spent on so-called linkages with other programs—including transportation for the elderly and handicapped which links clients to senior centers, community and medical services—than on any other program category.

The passage of OAA of 1965 has had a major impact on the development of transportation for older persons. Under title III of the Act, States are required to spend an adequate proportion of their title III–B funds on three categories: Access services (transportation and other supportive services); in-home, and legal services. In fiscal year 1987, nearly 8 million persons were recipients of transportation services under the OAA. Ten percent of OAA funds are used for transportation services. This level of participation and funding indicates the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage for the 1970 amendments to the Urban Mass Transit Act (UMTA) of 1964 (Public Law 98–453), which added section 16, marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities for improved access by the elderly and handicapped. Section 16 of UMTA declares it to be national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services. Section 16 also states that special efforts shall be made in the planning and design of mass transportation facilities and services so that the availability to the elderly and handicapped persons of mass transportation is assured, and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. Essentially, the goal of section 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavailable, insufficient, or inappropriate.

Another significant initiative was the enactment of the National Mass Transportation Assistance Act of 1974 (Public Law 93–503) which amended UMTA to provide mass transit funding for urban and nonurban areas nationwide through block grants. Under the program, block grant money can be used for capital operating purchases at the localities' discretion. The act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours. Also, passage of the Surface Transportation Assistance Act (STAA) of 1978 provided funding at the Federal level, known as the section 18 program, to support public transportation program costs, both operating and capital for nonurbanized areas. Elderly and handicapped people in nonurban and rural areas benefit significantly from section 18 projects because they generally are less mobile than other people and might be more isolated and in need of transportation assistance.

The STAA of 1982 established section 9 in its amendments to the UMTA Act. Section 9, a block grant program, replaces the former section 5 program (urban formula grants) and incorporates funding to continue the section 18 program. Section 9 provides assistance to the public in general, but some of its provisions are especially important to elderly and handicapped persons. Section 9 continues the requirement for recipients of Federal mass transit assistance to offer half-fares to the elderly and handicapped people during nonpeak hours.

The programs administered by the Department of Health and Human Services have proved highly successful in providing limited supportive transportation services necessary for linking needy elderly and handicapped persons to social services in urban and suburban areas. The Department of Transportation programs have been the major force behind mass transit construction nationwide and continue to provide basic funding sources for primary transportation services for older Americans. Despite these program initiatives, however, Federal strategy in transportation remains essentially one of providing seed money for local communities to design, implement, and administer transportation systems to meet their individual needs and resources. In the future, the Federal response to the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and, to a large extent, the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

2. Issues

(A) UNMET NEEDS

Medicare's Prospective Payment System (PPS) has placed increasing demands on transportation services. Under PPS, predetermined fixed payment rates are set for each Medicare hospital inpatient admission, based on the diagnosis-related group (DRG) into which that admission falls. This fixed payment is an incentive for hospitals to limit costs spent on Medicare patients either by reducing lengths of stay or the intensity of care provided. As a result, many older persons are being released from the hospital earlier and in need of more follow-up care than before the introduction of PPS. Consequently, State and area agencies on aging now are spending more of their transportation funds to transport older persons to dialysis and chemotherapy and less for grocery store and senior center transportation. One State (Kentucky), finding a statewide need for additional transportation services, particularly nonemergency services, characterizes transportation as its top priority. This same State conducted a survey and found that lack of transportation is a major barrier to mental health and social support services. Of those who had difficulty attending social activity programs, 52 percent cited the lack of transportation as the reason. This barrier results in less socialization and less satisfaction with life in general.

The lack of adequate transportation to social activities, the grocery store, and the doctor can have serious consequences for the well-being of many elderly. It also may set back some of the advancements in health status across the country that have been achieved through better access to services.

(B) TRANSPORTATION SERVICES FOR THE RURAL ELDERLY

Transportation was cited as one of the major barriers facing the rural elderly in a 1984 report published by the Senate Special Committee on Aging. According to the report, an estimated 7 to 9 million rural elderly lack adequate transportation, and as a result, are severely limited in their ability to reach needed serivces. The isolation of rural areas along with more limited availability of resources and uncertainty of institutional support make the transportation problems of rural elderly more acute than their urban counterparts. Roads sometimes are narrow and poorly paved, further hampering travel for the rural elderly. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessability rather than program design.

Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas complicates the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares necessary to support a rural transit system. Further, the physical design and service features of public transportation, such as high steps, narrow seating, and unreliable scheduling, discourage participation by the elderly.

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. In an effort to draw attention to these critical transportation issues, specific recommendations were made during the 1981 White House Conference on Aging directed at improving transportation for the rural elderly. A mini-conference on transportation for the aging which preceded the general conference recommended that State transportation agencies play a central role in developing responsive rural systems, with implementation for such a system initiated at the local level in order to ensure appropriate design for the unique needs of the individual community. The conference also recommended greater citizen participation at the policymaking level as well as at the advisory and implementation levels of transportation programs.

(C) TRANSPORTATION SERVICES FOR THE SUBURBAN ELDERLY

The graying of the suburbs is a phenomenon which has only recently received attention from policymakers in the aging field. Since their development following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have elapsed since have changed entirely the profile of the average American suburb. The suburbs have aged with profound implications for social service design and delivery. In 1980, for the first time a greater number of persons over 65 lived in the suburbs (10.1 million) than in central cities (8.1 million), a phenomenon that is continuing.

The availability of transportation services for the elderly suburban dweller is limited. Unlike large cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services generally. Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent, and consists mostly as a supportive service. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Often, alternative revenue sources are not politically expedient. For example, user fees alone are insufficient to support suburbanwide services and are generally viewed as penalizing those most in need of transportation services in the community—the elderly poor.

In 1984, researchers at the State University of New York in Albany received a grant from the National Institute of Child Health and Human Development to study the implications of older suburban populations on public policy, including transportation services. Their studies show that suburbs with a larger number of elderly have adjusted to the needs of their dependent population by providing substantially higher levels of municipal services than the typical suburb. However, this has been accomplished through a heavy reliance on high property taxes. The fact that communities with the greatest demand for services for the elderly are precisely the communities that lack a tax base to support these expenditures has intensified the fiscal squeeze; many already have reached the constitutional limit on taxing authority. Therefore, other sources of revenue are being tapped, such as lotteries and user fees, to help fund these additional community services.

The fact that the suburbs have aged has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a particularly critical need. Institutions that serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores, necessarily must be designed with supportive transportation services in mind. In addition, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems, such as dial-a-ride and van pools. Alternative funding mechanisms, such as reduced fares, user fees, and the local tax base, need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the degree that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand re-examination.

3. LEGISLATION

Funding for the most crucial transportation programs serving older Americans was put on hold during the closing days of the 99th Congress when the Surface Transportation and Uniform Relocation Assistance Act of 1986 died in conference committee after lawmakers were unable to come to agreement on several unrelated issues. States subsequently were left with limited funding.

Congress appeared intent on an early reauthorization in the 100th Congress. The House passed H.R. 2 on January 21, 1987, and the Senate passed its substitute bill, S. 387, on February 4, 1987. Both houses passed the omnibus highway conference bill, known as the Surface Transportation and Uniform Relocation Assistance Act of 1987, in mid-March. President Reagan, however, vetoed the legislation on March 27, objecting to provisions for 120 demonstration projects for particular States and congressional districts. Congress overrode the veto and the 5-year reauthorization act became law on April 2, 1987 (Public Law 100–17). Of the authorizations from the mass transit account of the trust fund for discretionary programs, $35 million was authorized for each year for the elderly and handicapped and innovative research programs. This section of the legislation which is cited as the Federal Mass Transportation Act of 1987 also provides for a 95 percent Federal share of the cost of all projects specifically targeted at improving elderly and handicapped access to public transit systems. Previously, the Federal share was 80 percent for all formula grant programs and 75 percent for discretionary grants. An additional provision directs the Secretary of Transportation to conduct a study of the feasibility of developing and implementing standards for the use of tactile mobility aids in mass transit projects. Use of such aids would facilitate the safe access to and use of federally funded transit facilities and equipment by visually impaired and legally blind persons.

Under the section cited as the Highway Safety Act of 1987, the legislation also included a provision that directs the Transportation Secretary to commission a National Academy of Sciences study of safety problems associated with older drivers and to establish a pilot program to improve older drivers' safety and mobility.

The continuing appropriations bill for fiscal year 1988 (Public Law 100-202) appropriated $35 million for elderly and handicapped, and innovative research programs under the discretionary grants of the Urban Mass Transportation Administration.

The Older Americans Act was also reauthorized in 1987 (Public Law 100-175). The amendments provide for a 5-percent increase for support services, including transportation services, each year for the next 4 years.

F. LEGAL SERVICES

1. Overview

Older persons, because of difficulties of access and unique legal problems, have a special need for legal services. This is primarily a result of the low incomes of many older persons and the complex nature of the programs upon which the elderly are dependent. After retirement, most older Americans are dependent on Government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security programs for income security and on the Medicare and Medicaid Programs to meet their health-care needs. These benefit programs are extremely complicated and often difficult to understand.

In addition to problems with Government benefits, older persons' legal problems typically relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home and probate matters. Legal services and professional legal representation are of vital importance to the elderly because they help them obtain basic necessities and assure that they receive benefits and services to which they are entitled.

Unfortunately, older persons encounter special problems in gaining access to legal services. A large number of older persons, particularly those who qualify for many benefit programs, cannot afford to hire a private attorney. Others are not comfortable accepting free or low-cost legal services and others are simply wary of dealing with members of the legal profession. In addition, many older persons may fail to recognize some of their problems as legal problems and may not be aware of existing legal services. Finally, many older Americans face specific barriers to legal services because of a lack of transportation, physical handicaps, fear of crime, and difficulty in communication.

As the elderly population continues to grow, so does their need for legal services. Private bar efforts alone fall far short in providing for the needs of older Americans. In addition to legal services provided by the private bar, a number of existing Federal programs provide legal services for older persons. Programs funded under the social services block grant established under the Omnibus Reconciliation Act of 1981, the Older Americans Act, and the Legal Services Corporation are among these programs. Of these three, the Legal Services Corporation is the largest provider of legal services to low-income elderly.

While everyone agrees that provision of legal services to the elderly is vital, there has been a controversy as to which legal services should be provided and how best to provide them. This dispute began in 1981 when President Reagan proposed to terminate the federally funded Legal Services Corporation. The controversy surrounding the provision of legal assistance to the poor can be seen in the history of the Legal Services Corporation, and has been played out in the funding, authorization, and nomination process for the Corporation. While the controversy goes on, it is significant that Congress has consistently opposed President Reagan's proposals to abolish the Legal Services Corporation.

2. Background

(A) THE LEGAL SERVICES CORPORATION

Legislation creating the Legal Services Corporation (LSC) was enacted in 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. President Nixon, however, recognized that because some of the litigation initiated by legal services brought it in direct conflict with local and State governments and because the program is concerned with social issues, it is subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, he requested legislation creating a separate, independently housed corporation. The Legal Services Program then was established as a private, nonprofit corporation headed by an 11-member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been admitted to a State bar. The Corporation also funds a number of national support centers, which develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field.

Legal services provided through Corporation funds are available only in civil matters and to any individual with an income no higher than 125 percent of the Office of Management and Budget poverty guidelines. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. According to the most recent report of the Corporation in 1985, almost one-third of legal services cases are family related, such as divorce and separation, child custody and support, and adoption. Another 19 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in non-Government subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems, form the next two largest categories of legal services cases. Individual rights, employment, health, juvenile, and education cases make up the remaining caseload. Most cases are resolved outside the courtroom.

At the national level, the LSC has funded national support centers for field attorneys and State support centers. Four of these centers are involved specifically in issues that confront older people: The National Senior Citizens Law Centers, in Los Angeles and Washington, DC; Legal Counsel for the Elderly, in Washington, DC; and Legal Services for the Elderly in New York.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several others have been added since then. Most of the restrictions were made in response to critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys under the guise of providing legal assistance to the poor. Opponents believe that although legal services attorneys theoretically are prohibited from pursuing their own political and social interests by a requirement that they represent a particular client before getting involved in an issue, this requirement easily is circumvented without specific restrictions. The current restrictions include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The fiscal year 1987 appropriations measure (Public Law 99-500) contained additional prohibitions against lobbying with Corporation funds, representing aliens who do not meet specified conditions, and class action suits against Federal, State, or local governments except under certain circumstances.

Other restrictions were promoted by supporters of legal services who were concerned that the broad scope of the Corporation's work would be curtailed sharply by its detractors. For example, the 1987 appropriations measure also require prior notification of Congress when regulations are to be promulgated. This restriction was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would change drastically existing Corporation policy.

The fiscal year 1988 continuing appropriations measure (Public Law 100-202) retains the restrictions Congress added in 1987.

(B) OLDER AMERICANS ACT

Support for legal services under the Older American Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AoA) for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were among those made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 identified for the first time, legal services as eligible for funding under title III of the OAA. Amendments to the OAA, in 1978, established a funding mechanism and a programmatic structure for legal services. Area agencies on aging are required by the Older Americans Act to allocate an adequate proportion of title III supportive services funds for legal assistance. The 1984 amendments to the Act added a requirement that area agencies annually document funds expended for this assistance. The Act also requires that area agencies contract with legal assistance providers who can demonstrate the experience or capacity to deliver legal assistance and to involve the private bar in legal assistance activities. If the legal assistance grant recipient is not also a Legal Services Corportion grantee, coordination with LSC-funded programs is required.

Unfortunately, the amount of title III funds expended on legal services for recent fiscal years is not available. As part of its past efforts to reduce State reporting burdens, AoA discontinued the requirement that States report expenditure data on types of services. According to the AoA fiscal year 1986 Program Performance Report, about 525,000 persons received legal services.

The OAA requires State agencies on aging to establish and operate a long-term care ombudsman program to, among other things, investigate and resolve complaints made by or on behalf of residents of long-term care facilities. The 1981 amendments to the OAA expanded the scope of the ombudsman program to include board and care facilities. The 1987 amendments (Public Law 100–175) requires States to ensure protection from liability, willful interference, and retaliation in the good faith performance of ombudsman duties. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal and protective services activities for older people and to assure coordination of these activities. State ombudsman reports and a survey by the American Association of Retired Persons in 1987 indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to facilities, residents, and residents' records; provide consultation to ombudsman on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs, and work with ombudsmen and others to bring about changes in policies, laws, and regulations which benefit older persons in institutions.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, provide services directly or contract with public and nonprofit social service agencies for providing social services to persons and families. For the most part, States determine which social services to provide and for whom they shall be provided. Services may include legal aid. Because the Omnibus Budget Reconciliation Act of 1981 eliminated much of the reporting requirements previously included in the title XX program, little information is available on how States have responded to both funding reductions and changes in the legislation. As a result, there is no information available on the number of persons or the age breakdown of those persons who are being served.

3. ISSUES

(A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. Federal legal services reporting systems count older persons on the basis of those over 60. More than 40 million Americans (about 17 percent of the national population) were over 60 in 1987. Persons over 60 constitute 12 percent of all persons at or below the official Government poverty line. This is approximately 5 million persons. Under current eligibility requirements, individuals with incomes up to 125 percent of the poverty level may be eligible for LSC funded legal assistance. Using this standard, approximately 9 million persons over 60 are LSC-eligible. Unfortunately, there is no precise way of determining eligibility for legal services under the Older Americans Act since eligibility is based on both economic and social need, and means testing for eligibility is prohibited. Nevertheless, it is clear that a substantial percentage of older persons are poor or near-poor and would find it difficult to purchase legal representation.

LSC programs handled and closed 1,391,379 cases in fiscal year 1987. Although programs funded under the Legal Services Corporation Act make services available to all low-income persons, persons 60 years of age and older constitute a sizable portion of the client-eligible population. About 12.36 percent of the cases handled in 1987 involved a client age 60 or older. This figure represents a decrease from 1982 of 14 percent.

An essential component of legal services delivery systems for the elderly is the private bar. The expertise of the private bar is considered especially important in areas such as wills and estates as well as real estate and tax planning. Many elderly persons cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar generally is unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations, with little chance of generating a fee for services rendered. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee, (pro bono) basis, the potential of the private bar to serve the elderly in need of legal assistance has not yet been fully realized.

The availability of legal representation for low-income older persons is also determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut back the flow of Federal dollars to local programs for the delivery of elderly legal services and there is no doubt that older persons are finding it more difficult to obtain legal assistance. When the Legal Services Corporation was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of 2 legal services attorneys for every 10,000 poor people. In fiscal year 1980, the goal of minimum access was achieved with an appropriation of $300 million. Currently, however, the LSC is not funded to provide minimum access to legal assistance for poor persons. In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 persons above the Federal poverty line.

In 1987, LSC concluded its 2-year Elderlaw Project which had three purposes:

(1) Develop classroom and bar association source materials on law affecting the elderly,

(2) Increase pro bono efforts on behalf of elderly clients, and

(3) Develop a law school clinical program for elderly clients to supplement services being provided by legal services grantees. Materials developed include a series of videotapes on Medicare, a consumer manual on nursing homes, and a textbook on the topic of law and aging for use in law schools. LSC reports that in the 20 law school clinics, the legal problems of more than 6,500 elderly clients were handled by approximately 1,000 students. Ninety percent of the students report that they became aware of the legal problems of the elderly poor through their work with these clinics, and the exposure has increased their willingness to provide future services on a pro bono or reduced fee basis. LSC currently is funding 26 law school clinics in academic year 1987–88.

The Private Attorney Involvement (PAI) project requires each LSC grantee to spend at least 12.5 percent of its basic field grant on the direct delivery of legal services by private attorneys (as opposed to LSC staff attorneys). LSC states that data indicates that the PAI requirement is an effective means of leveraging funds, closing a higher percentage of cases per $10,000 of funding with PAI dollars than with dollars supporting staff attorneys.

It should be noted, however, that these programs have been criticized by legal services staff attorneys. They claim that they have been unjustifiably cited to support less LSC funding and to divert cases from LSC field offices.

In 1981, Congress reduced funding to the LSC by 25 percent (from $321 million to $241 million), resulting in the immediate loss of 1,793 attorneys and the closing of more than 108 local offices, making it more difficult for older persons with legal needs to gain access to legal representation. In fiscal year 1987, there were 306 legal services programs in the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices in 1987 was approximately 1,156, down from 1,475 in 1981. At the end of 1987, the LSC employed 4,447 attorneys, as compared to 6,559 in 1980.

Cuts in funding also coincide with a national economic recession creating a category of "new poor" and changes in Federal programs creating new legal needs for the poor. Since 1981, there has been an additional decrease in the LSC's ability to meet clients' legal needs. Legal services field offices report having to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must now make hard choices about which poor persons will be denied service and which will receive legal attention.

(B) ALTERNATIVE PROVIDERS

Few people disagree that provision of legal services to the elderly is important and necessary. Yet there has been continuing controversy as to how best to provide these services. This dispute was touched off again when President Reagan proposed in 1981 to terminate the federally funded Legal Services Corporation and to include legal services activities in a social services block grant. Funds then going to the Corporation, however, were not proposed for inclusion in the block grant. The block grant approach is consistent with the administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and that allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

At the time of this proposal, the administration revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges resparked a controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their programs are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the government and businesses to enforce poor peoples' rights have angered some officials. Others protest against the use of group orientation methods on the basis that the the poor can be protected only by allocation and litigation procedures which treat each poor person equally as a unique individual and not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits have been severely restricted.

President Reagan also justified his proposal to terminate the Legal Services Corporation by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a congressionally mandated study which found legal services provided by private attorneys to be as effective as those provided by staff attorneys hired directly by local legal services programs. Their approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation. Finally, the administration argued that regardless of the continued existence of LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals.

Supporters of federally funded legal services programs argue that neither State nor local governments nor the private bar would be able to fill the gap in services created by abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will move forward to provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are not as likely to have this experience nor are they as likely to have the interest in dealing with the systematic abuses that poor people encounter.

Defenders of LSC say that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the Corporation and the private bar. One author has concluded that only about 15 percent of the legal problems of the poorest segment of the population receive any kind of legal attention. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their Government and to the whole system of justice. They contend that it is also inconsistent to assure low-income people representation in criminal matters, but not to provide them with legal assistance in civil cases.

(C) CONFIDENTIALITY AND REPORTING REQUIREMENTS

The issue of attorney/client confidentiality has been a common source of tension between area agencies on aging and legal assistance providers who receive funding from title III of the Older Americans Act. Area agencies on aging must ensure that the legal assistance funds they provide are being effectively spent. In their efforts to monitor performance, some area agencies have requested lists of clients or sought access to client files. Some area agency staffs claim that legal providers use the attorney's professional obligation of confidentiality to withhold information unnecessarily. Often, legal providers think that the area agency staff do not have adequate understanding of the importance of confidentiality of clients' names, privacy in interviews, and restrictions on access to case files. Consquently, some legal assistance providers are reluctant to contract with area agencies on aging.

The conflict was considered during the 1984 reauthorization of the Older Americans Act. Although report language in the Senate version of the Older Americans Act amendments legislation made it clear that legal assistance providers under the Act should not be required to divulge information to area agencies on aging which reveals the identity of clients served under title III funds and recommended the use of an independent auditor, the subsequent legislative language and regulations did not sufficiently clarify the issue and legal services providers and areas agencies continued to be at odds in the pursuit of their respective obligations.

4. RESPONSES

(A) LEGISLATION

(1) The Legal Services Corporation

(a) Budget Legislation

The 1974 LSC Act was reauthorized in 1977 for three additional years. At that time, much of the controversy surrounding the program, which grew from a perception that the program was one of social activism and reform rather than routine legal assistance, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has re-emerged. This is due, in part, to the fact that every year since 1981, the Reagan administration has announced plans not to seek reauthorization of the program and has requested no funding for it. Congress, however, has rejected these proposals and has responded with bipartisan support to restore funding.

Funding for the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in 1981. Since then, however, funding for LSC has been reduced. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. This level was maintained in 1983. In 1984, $275 million was appropriated for the LSC (Public Law 98–107). For fiscal year 1985, President Reagan again proposed to eliminate the Legal Services Corporation. The Corporation itself, however, requested $325 million. Congress passed and the President signed a measure (Public Law 98–411) providing fiscal year 1985 funds for a number of Federal agencies, including $305 million for the LSC.

Further provisions in Public Law 98–411 earmarked $2 million to the LSC to increase "quality legal services to the elderly" through what became known as the Elderlaw project discussed above. In implementing this project, the Corporation solicited proposals nationwide. After extensive review, LSC granted a total of $1.6 million to 20 law school clinics, $140,000 for the development of 6 sets of source materials, and a total of $222,820 to 11 private bar pro bono projects. The projects were funded in 1985 by the Elderlaw project and ended in 1987.

A supplemental appropriation for fiscal year 1985, containing $8 million for the establishment of a new poverty law center in New Orleans and for a legal clinic at the Drake University School of Law in Des Moines, IA was signed into law in 1985 (Public Law 99–88). This brought total fiscal year 1985 funding to $313 million.

President Reagan requested no funding for the Legal Services Corporation for fiscal years 1986 and 1987, but the Corporation submitted a budget request directly to Congress each time. Congress subsequently appropriated $305.5 million for each fiscal year. Under the Gramm-Rudman-Hollings Act (Public Law 99–177), the LSC appropriation was reduced by 4.3 percent, or by about $13.1 million for fiscal year 1986. The legislation for fiscal year 1987 included language directing that provisions regarding legislative and administrative advocacy in previous appropriations bills and the Legal Services Corporation Act of 1974, as amended, shall be the only valid law governing lobbying and shall be enforced without regulations. This language was included because the Corporation published proposed regulations which were believed to go far beyond the restrictions on lobbying which are contained in the LSC statute.

For fiscal year 1988, Congress appropriated $305.5 million for the LSC. The administration again requested zero funding. The continuing appropriations resolution for fiscal year 1988 (Public Law 100-202) again earmarks the funding levels for each of the Corporation's line items in the bill to ensure that the Appropriations Committee's recommendations are carried out. The committee also directs the Corporation to submit plans and proposals for the use of funding at the same time it submits its budget request to Congress. This was deemed necessary because the committee has encountered great difficulty in tracing the funding activities of the Corporation and received very little detail from the Corporation about its proposed use of the funding request, despite repeated requests for information.

The appropriations bill also includes a legislative formula governing the allocation of funds for grants and contracts among the basic field programs. Provisions effective in fiscal year 1988 that are continued from past years' appropriations include restrictions on nontherapeutic abortions, lobbying, class action suits, representation of aliens, and language requiring prior notification of the Congress when regulations are to be promulgated.

The Corporation is also prohibited from imposing requirements on the governing bodies of recipients of LSC grants that are additional to, or more restrictive than, provisions already in the LSC statute. This provision includes the procedures of appointment, including the political affiliation and length of terms of office of members, and the size, quorum requirements, and committee operations of the governing bodies.

(b) Elimination of Support Centers

During 1987, congressional concern about the LSC focused on the Corporation's attempt to cut off funds to the national and State support centers, computer assisted legal research, LSC-funded training centers, and the network of programs designed to aid migrant workers.

At a meeting in October, the LSC Board approved 6-5 a motion for the cutoff. In the Senate, an effort was made to implement LSC's intent in the form of an amendment to the appropriations continuing resolution. However, the Senate viewed the LSC proposal as an attempt to change the structure of the Corporation, instituting in its place a voucher system, and soundly defeated the proposed amendment by a 70-28 vote. It was pointed out during Senate debate that the 17 national support center staffs provide the only in-depth coverage of issues of special importance to poor people—affordable health care and housing, Social Security, consumer problems, welfare, and employment—and, are expert in the interpretations of regulations, statutes, administrative and legislative procedures in these areas.

In a survey of legal services program directors conducted by the LSC itself, 90 percent urged the continuation of national support centers rather than a proportional increase in their own program funding. The $7 million that goes to national support centers would provide less than a 3-percent increase for each field program, an increase so small that it would not fill the gap that would be created by the loss of specialized assistance.

(c) Board Appointments

Since President Reagan took office in 1981, there has been continuing conflict between the White House and the Congress over appointees to the LSC's board of directors. During the summer of 1981, the appointments of all 11 LSC board members appointed by former President Carter expired. President Reagan, however, did not appoint new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Between 1981 and 1984, he appointed a succession of people to the board on an interim basis. Because these appointments were made while Congress was in recess, they could serve without any Senate confirmation. During the same period, President Reagan announced a number of prospective nominees, but none was confirmed by the Senate. Some of them were opposed by liberals and moderates who questioned their qualifications and their commitment to legal services to the poor. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. In 1984, President Reagan granted recess appointments to 11 individuals he had unsuccessfully nominated earlier in the year. These people served without Senate confirmation until the end of 1985. The names of these individuals, however, also were re-submitted formally to the Senate on January 3, 1985, when the Congress convened. Although a couple of the nominees were controversial and faced stiff opposition, all were approved by the Senate Labor and Human Resources Committee and subsequently by the full Senate on June 12, 1985.

In June 1986, the President resubmitted the names of three board members for a second 3-year term. The names of two client board members whose terms also expired in July 1986 were not resubmitted nor were their replacements named. All of the current board members will continue to serve until they are replaced by themselves or some other persons who have been confirmed by the Senate.

In 1987, the President nominated four persons to the LSC board. These nominations awaited confirmation by Congress at the time of adjournment in December.

(2) Older Americans Act

In response to the conflict between legal assistance providers and area agency staff on confidentiality and reporting, the 1987 amendments to the Older Americans Act (OAA) (Public Law 100-175) specifically provides that State and area agencies may not require title III legal providers to reveal information that is protected by the attorney-client privilege.

The OAA 1987 amendments also require the State agency to establish a minimum percentage of title III B funds which each area agency must spend on legal services and requires the area agencies to spend an adequate proportion of the funds on legal services, defined as the minimum percentage established by the State agency. In addition, prior to granting a waiver of this requirement, the State agency must provide a 30-day notice period during which individuals or providers may request a hearing, and offer the opportunity for a hearing to any individual or provider who makes such a request. The conference report on the Act's amendments states that the minimum percentage is intended to be a floor, not a ceiling. Area agencies on aging are encouraged to devote additional funds to legal services, as well as access and in-home services, to meet local needs.

Four national organizations have continued to receive funding from the Administration on Aging in 1987 to support legal services activities: Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons); the American Bar Association; the Center for Social Gerontology; and the National Senior Citizens Law Center. In addition, in 1987, the Administration on Aging awarded grants to three additional national legal service organizations to work with States and area agencies on aging to help vulnerable older individuals with legal problems: The Pension Rights Center; National Bar Association; and National Clearinghouse for Legal Services.

(B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such programs are gaining momentum, there is no precise way to determine the number of lawyers actually involved in volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys. This assessment is noteworthy in light of the fact that President Reagan has justified his desire to abolish the LSC by saying that legal services for the poor could be provided more efficiently by members of the private bar.

A recent development in the delivery of legal services by the private bar has been the introduction of the Interest on Lawyers' Trust Accounts (IOLTA) program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled into federally funded, bar affiliated, and private and nonprofit providers of legal services. IOLTA programs have grown rapidly. There was one operational program in 1983, today 42 States have adopted IOLTA programs that are bringing in funds at a rate of $32 million per year. The Legal Services Corporation reported receiving $2.6 million through IOLTA in 1985. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. Supporters of the concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how the money is spent. While there is no unanimity at this time among lawyers regarding IOLTA, it appears to have potential value as a needed funding alternative.

In 1977, the president of the American Bar Association (ABA) was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1978. The Commission was charged with examining four priority areas—provision of legal services to the elderly, discrimination against the elderly, simplification and coordination of administrative procedures and regulations, and issues involving long-term care. Subsequently, two new priority areas were added: housing and social security. Since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The Commission has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged. One such activity was the national bar activation project which provided technical assistance to State and local bar associations, law firms, corporate counsel, legal service projects, the aging network, and others in developing projects for older persons. As a follow-up to that project, the Commission developed a series of packages focusing on:

(1) How bar associations can create and maintain an active committee on the elderly,

(2) How State and area agencies on aging can approach the private bar,

(3) How the aging and legal networks can develop pro bono legal assistance for the elderly,

(4) How to integrate the concept of lifetime planning for the elderly into the private bar, and

(5) How bar associations can use the media to provide community legal education for the elderly. In addition, the Commission publishes a quarterly newsletter, Bifocal, and acts as a clearinghouse for private bar activities to assist the elderly.

The private bar has also responded to the needs of elderly persons in new ways on the State and local level. Currently, there are about 40 State and local bar association committees on the elderly. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people to providing community legal education for seniors. Nearly 50 State and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In more than 38 States, handbooks which detail seniors' legal rights have been produced either by State and area agencies on aging, legal services offices, or bar committees. Since 1982, attorneys in more than half the States have had an opportunity to attend continuing legal education seminars regarding issues affecting elderly people. The emergence of training options for attorneys that focus on financial planning for long-term care and advance directive are particularly noteworthy.

As recognized by the American Bar Association, private bar efforts alone fall far short in providing for the needs of older Americans for legal help. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is through the combined efforts of a continuing Legal Services Corporation, an effective Older Americans Act program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.

G. PROGNOSIS

Despite Federal funding cutbacks, States will continue to spend as much of their block grant funds on social services for older persons as is feasible. However, these expenditures will focus increasingly on emergency services rather than on coordinated long-term services. States will find it increasingly necessary to utilize multiple funding sources to support their programs for the elderly. The lack of data on how the funds are used may call for reinstituting a reporting system.

The Stewart B. McKinney Homelessness Assistance Act of 1987 marks the first major piece of legislation that has addressed the homelessness issue. It is hoped that the many programs initiated under various departments will begin to provide some relief to those who suffer from one of the more serious social issues in the country. Since the elderly comprise a high percentage of the homeless, strategies for reaching them will be tested throughout the country. Preliminary attempts have found that many of the homeless elderly are depressed, have problems with interpersonal relationships, and have difficulty with transitional housing. Strategies to reach the homeless elderly must be developed to go beyond the provision of temporary shelter.

A greater Federal effort might be made to define adult illiteracy and collect the data to determine the actual size and scope of the problem. The complexity of the issue—and its relation to national productivity, security, and welfare—suggests the need for a Federal concern beyond program funding or public awareness campaigns.

The Older Americans Volunteer Programs and VISTA will continue to receive broad bipartisan support because they have proven to be cost-effective with measurable human benefits as well.

In view of increasingly limited Federal participation in transportation services, the role of State and local governments in the transportation area will become of major significance to needy elderly and handicapped persons. States will need to reassess priorities with attention toward replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in terms of providing transportation services to older Americans. A report for the Administration on Aging on the transportation problems of older Americans indicated that many agencies servicing the elderly already extensively use volunteers in their programs. Given the stringency in resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

It is a basic tenet in our society that those who live under the laws should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded legal services program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. If we are to continue to make progress in the goal of equal justice and access for all, the continued funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

Chapter 14

FEDERAL BUDGET

OVERVIEW

The fall of 1987 was an eventful time for Congress and Federal budget reform. In September, legislation was signed into Public Law 100–119 which served to amend and reform the Balanced Budget Act of 1985 (Gramm-Rudman-Hollings). This legislation, a debt-limit extension measure (H.J. Res. 324), revised the deficit targets and stretched out to fiscal year 1993 the timetable for achieving a balanced Federal budget. The 1987 law also reinstituted an automatic mechanism for sequestration to be triggered by a report issued by the Director of the Office of Management and Budget (OMB). (Sequestration permanently cancels previously allocated budgetary resources to achieve a required amount of outlay savings.) [1]

The October 19 stock market crash along with the approaching November 20 Gramm-Rudman-Hollings automatic sequestration deadline (which severely threatened defense, as well as almost every other segment of the budget), prodded President Reagan into agreeing to a budget summit with congressional leaders in an effort to calm the financial markets. In these negotiations, all elements of the budget, with the exception of Social Security, were on the table. A compromise summit agreement on deficit reduction measures was reached on November 20, with its contents eventually incorporated into the omnibus appropriations and reconciliation measures enacted into Public Laws 100–202 and 100–203 on December 22.

A. BACKGROUND

1. The Budget Process

The Federal budget process is a prime example of the American Government's concept of shared powers. The provisions of Article 1 of the Constitution relating to the "power of the purse" gives Congress primary control over financial affairs. However, while the budget is not explicitly mentioned in Article II detailing executive powers, the President's general prerogative to see that the laws are faithfully executed makes the President a major partner in the budget process. From the outset, Congress has had to rely on the discretion of executive branch officials to implement the legislative provisions regarding public expenditures.

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[1] This chapter was prepared with the assistance of Virginia A. McMurtry, specialist in American National Government, Federal Budget Process Section, Government Division, Congressional Research Service, the Library of Congress.

The Constitution does not contain specific provisions regarding a budget process. Informal procedures were developed and sufficed for many years until the Budget and Accounting Act of 1921 provided the framework for executive budgeting. This law requires the President to submit a consolidated budget proposal to the Congress each year. The President's budget, which has the status of recommendations, provides the starting point for congressional consideration of upcoming budgetary decisions.

Although in recent years Congress has used the vehicle of a single omnibus continuing resolution to fund the entire Federal Government, this should not be considered normal budget procedure. Rather, appropriations for the coming fiscal year are supposed to be enacted in 13 separate appropriations bills, each of which is the focus of a subcommittee of the House and Senate Appropriations Committees. The Appropriations Committees are supposed to conform to provisions in the "authorizing" legislation, emerging from the numerous authorizing congressional committees.

In practice, particularly in recent Congresses, this procedure has not been closely followed. After the enactment of the regular appropriations for a given fiscal year, it is sometimes necessary to provide additional funding in a supplemental appropriations measure. Further, when appropriations laws are not enacted before the start of the fiscal year on October 1, short-term continuing resolutions often are used to provide temporary funding and allow Government operations to continue uninterrupted.

2. CONGRESSIONAL BUDGET RESOLUTION AND RECONCILIATION LEGISLATION

The budget process underwent substantial change as a result of the Congressional Budget and Impoundment Control Act of 1974. This law sought to restore to Congress some of the fiscal powers which had been surrendered over the years to the President by providing for a more coordinated and systematic congressional decisionmaking approach to the budget. The intent was to improve Congress' ability to view the budget as a whole and also to promote discipline among the authorizing committees.

The 1974 Budget Act established a congressional budget process centered around a concurrent resolution on the budget, scheduled for adoption prior to legislative consideration of revenue, spending, or debt-limit measures. (The law originally provided for adoption of two budget resolutions each year, but was amended in 1985 to provide for a single resolution to be adopted by April 15.) The budget resolution then sets the parameters for subsequent spending and revenue decisions which are made in separate tax bills, appropriations bills, and other measures.

Another component of the congressional budget process provided for in the 1974 law and in use since 1980 is the reconciliation process. This is a procedure to change existing laws to conform spending and revenues with the decisions in the budget resolution. The submissions from the committees are assembled by the House and

Senate Budget Committees into a single reconciliation measure. According to the timetable, the deadline for action by Congress on reconciliation is supposed to be June 15.

B. THE GRAMM-RUDMAN-HOLLINGS ACT OF 1985

In recent years, Congress has become increasingly frustrated with its budget process. Efforts to control the deficit in the context of appropriations bills have caused numerous delays and additional differences complicated the ability to produce conference reports. Congress has resorted to a series of continuing resolutions to permit agencies and departments to continue to pay salaries and operate programs until their regular appropriations become law. Reconciliation bills have been delayed further and further each year, to where the reconcilation bill for fiscal year 1986 was not passed until April 6, 1986—more than 6 months after the fiscal year started on October 1, 1985.

The Federal deficit has increased at what most consider to be an alarming rate. The total national debt surpassed the $2 trillion mark in 1985. Concerned about the potentially harmful economic effects of spiraling debt and spurred by constituent pressure to control the deficit, Congress searched for measures to enforce discipline in the budget process and limit congressional discretion. Measures proposed have included a constitutional amendment to require Congress to report a balanced budget each year and legislation to provide the President with authority to veto individual line items in appropriation bills.

1. History of the Act

The need to raise the debt ceiling above $2 trillion in the fall of 1985 triggered a response in the Senate. In September, Senators Phil Gramm, Warren Rudman, and Ernest Hollings offered an amendment to the debt ceiling bill to reform the budget process by forcing the Congress to achieve specific deficit reductions targets each year to eliminate the deficit by 1991. Early versions of the bill received considerable bipartisan interest from both Houses as well as from the White House. Many Members feared the political and economic consequences of increasing deficit spending, yet were unwilling to set automatic reductions in motion. However, pressures to reduce the deficit were overwhelming and the Balanced Budget Act was signed into Public Law 99-177 in December 1985.

2. Deficit Reduction Targets and Sequestration

Gramm-Rudman-Hollings provides for annual reductions in the budget deficit. To reach the original goal of a balanced budget by fiscal year 1991 (stretched out to fiscal year 1993 by the 1987 amendments), it specifies deficit targets for intervening years. In any year in which deficit targets are exceeded, the excess amount is to be automatically cut from the budget under a process known as sequestration. The Act allows for a $10 billion margin-of-error over the deficit target for each year except the last, before sequestration occurs. The 1987 revisions also set maximum sequestrable amounts for fiscal year 1988 and 1989 at $23 billion and $36 billion respectively.

The Gramm-Rudman-Hollings sequestration process does not list specific cuts for particular programs, but calls for aribtrary, across-the-board reductions in all programs not specially protected. Only when Congress and the President do not pass a budget within the target limit will automatic spending cuts be set in motion. When this occurs, the excess deficit is to be divided in half, one-half of the cuts is taken from the defense budget and the other half from domestic programs. The act sets up a procedure for calculating the resulting cuts in each program. Cuts in each program must come from unobligated funds. Obligated funds cannot be cut because this would put the Government in a position of breaching numerous contracts and commitments.

Gramm-Rudman-Hollings originally provided that a Presidential sequestration order be triggered automatically upon the issuance of a sequestration report (prepared by the Comptroller General of the General Accounting Office) which projected a deficit for a fiscal year in excess of the amount allowed under the act. This procedure was invalidated in 1986 by the Supreme Court, which, in *Bowsher* v. *Synar,* found the procedure to be unconstitutional because it violated the separation-of-powers principle by vesting executive power in a legislative branch officer. However, in anticipation of the possible invalidation of the automatic triggering procedure, Congress included fallback procedures in the act. These provided for the triggering of sequestration dependent upon the enactment into law of a joint resolution setting forth the contents of the joint Office of Management and Budget/Congressional Budget Office sequestration report. The 1987 revision further modified the process by restoring an automatic mechanism for sequestration, triggered by an OMB report.

3. REDUCTIONS IN PROGRAMS AFFECTING THE ELDERLY

Gramm-Rudman-Hollings controls the funding for Federal programs in two ways. First, the deficit targets encourage Congress to reduce spending by cutting or even restructuring programs. Second, if targets are not met and sequestration is called for, programs affecting senior citizens would be affected, at least partially, by the automatic cuts. Benefits paid under Social Security, Railroad Retirement Tier I, Medicaid, Foodstamps, SSI, and veterans pensions are fully protected from sequestration. However, no such protection is given to the administrative costs of these programs, and there is a danger that the quality of service might deteriorate.

The Federal civil service and military retirement programs, Railroad Retirement Tier II, and Black Lung disability, originally were subject to reductions up to the full amount of the annual cost-of-living adjustments (COLA's). In fact, as directed by Gramm-Rudman, the 3.1 percent COLA's scheduled to go into effect January 1, 1986, were canceled under a Presidential sequestration order and reaffirmed by Congress after the Supreme Court decision. Subsequent legislation, however, has exempted these programs from further sequestrations.

If deficit targets are not met, most health care programs including Medicare, veterans' health care and community health centers are subject to cuts in excess of inflation, but not more than 2 percent. When a sequester occurred in fiscal year 1986, these programs were reduced by 1 percent. Although benefits were not directly reduced, payments to health care providers were cut, straining hospital resources. Further abrupt reductions in payment levels could result in reduced quality of care for Medicare and Medicaid beneficiaries.

Other domestic programs on which the elderly depend are vulnerable to unlimited across-the-board reductions based on a uniform percentage of current spending. When exempted and specially treated programs are removed from nondefense spending, approximately one-sixth of total outlays remain and these programs are particularly vulnerable to severe reductions. In fiscal year 1986, for example, programs which provide important services such as housing, low-income energy assistance, older Americans programs, social services, transportation, health research into Alzheimer's and other diseases, block grants, and home weatherization projects were cut by 4.3 percent.

4. Legislation Affecting Gramm-Rudman-Hollings in 1987

At the conclusion of the second session of the 99th Congress in 1986, it was evident that congressional budget reform would be an important issue before the 100th Congress. Despite some notable legislative accomplishments, such as the Tax Reform Act of 1986, Members expressed continued dissatisfaction with the outcome of Federal budget policies and the operation of legislative budgeting procedures.

Much of the criticism focused on the level of the deficit. Although sequestration had been avoided for fiscal year 1987 by the enactment of several deficit reduction measures, some Members predicted that the actual deficit would exceed the target by a wide margin, like in fiscal year 1986, because of unduly optimistic economic assumptions and other factors. Additionally, some Members complained that the two principal deficit reduction measures for fiscal year 1987, the Tax Reform Act and the Omnibus Budget Reconciliation Act of 1986, would make deficit reduction even harder in future years. Reconciliation, they maintained, relied on the use of gimmicks such as postponing payments so that they fall into the next fiscal year, and one-shot savings like selling Federal loan assets. The tax reform law was expected to reduce the fiscal year 1987 deficit by about $11 billion, but add $15 billion or so to the deficits for fiscal years 1988 and 1989.

In August 1986, the Senate passed a measure raising the debt limit with an amendment restoring an automatic sequestration trigger. (This was in response to the 1986 Supreme Court ruling which invalidated the automatic trigger for sequestration.) The House and Senate did not go to conference on the sequestration proposal, however, and Congress extended the debt limit until May 15, 1987. Proponents of the automatic sequestration trigger vowed to renew their efforts at that time.

The initial OMB/CBO joint sequestration report for fiscal year 1988, issued in August 1987, projected a fiscal year 1988 deficit of $153 billion—$45 billion above the statutory target. Sequestration implemented according to the terms of this report (without any modification of the deficit target) would have required that outlays be reduced by 12.9 percent for defense programs and 19 percent for nondefense programs. There was widespread agreement that cuts of this magnitude not only would be overly severe, but also could actually harm the economy.

After months of debate about how to fix the Gramm-Rudman-Hollings sequestration process and modify the deficit targets, Congress in September 1987 enacted changes in the 1985 Balanced Budget Act as part of H.J. Res. 324 extending the permanent statutory limit on the public debt. The two major purposes of these changes were to restore the automatic trigger for sequestration that had been invalidated by the Supreme Court and modify the timetable for achieving a balanced budget in light of persistent high deficits. (See table 1.)

TABLE 1.—ORIGINAL AND REVISED DEFICIT TARGETS IN THE 1985 BALANCED BUDGET ACT AS AMENDED

[Amounts in billions]

Fiscal year	Original target	Revised target
1986	171.9	
1987	144	
1988	108	144
1989	72	136
1990	36	100
1991	0	64
1992		28
1993		0

C. BUDGET LEGISLATION

1. Administration's Proposals for Fiscal Year 1988

When President Reagan submitted his budget proposal for fiscal year 1988, he projected revenue increases of $22.4 billion and, to comply with the unrevised Gramm-Rudman-Hollings deficit target of $108 billion, cuts of $18.7 billion in spending for nondefense programs. Spending cuts in human resource programs would have made up half of the reductions, according to the President's budget, which proposed reducing Medicare outlays by $5.2 billion and Medicaid by $1.4 billion. Another large reduction was proposed for Federal employees' retirement programs ($1.5 billion), but no changes were proposed in Social Security. With regard to revenue increases, the President proposed several small revenue-raising adjustments to the tax code and certain new or higher user fees.

2. Congressional Budget Resolution

When the House on April 9 approved H. Con. Res. 93, the concurrent resolution on the budget for fiscal year 1988, it called for total budget authority of $1.142 trillion and outlays of $1.039 trillion. With total revenues projected to be $930.9 billion, that left an projected deficit of $107.6 billion. The Senate version, S. Con. Res. 49, approved on May 5, called for total budget authority of $1.173 trillion and outlays of $1.061 trillion, and for total revenues of $927.8 billion, leaving an OMB projected deficit of $107.8 billion.

Conferees for the House and Senate remained deadlocked for more than a month, but finally agreed to a compromise 1988 budget resolution on June 18, providing for budget authority of $1.153 trillion, outlays of $1.041 trillion, and revenues of $933 billion, for a projected deficit of $108 billion. The House approved the conference compromise on June 23 and the Senate followed suit the next day.

The April 15 deadline for completion of congressional budget resolution was missed by more than 2 months. Provisions in the resolution agreed to in June would have frozen spending for most domestic programs at 1987 levels, or allowed for increases adjusted only for inflation. Increases in the defense budget were pegged to the enactment of new taxes. However, in the fall of 1987, the budget blueprint provided in the resolution, like the President's 1988 budget proposal earlier in the year, became outdated and superceded by the provisions of the budget summit agreement.

3. Appropriation Measures

After much wrangling between the House and Senate, H.R. 1827, providing supplemental appropriations for 1987 was signed into law on July 11 (Public Law 100–71). The supplemental provided total budget authority of approximately $9.4 billion, and included among its highlights about $6.5 billion for discretionary domestic spending, $1.2 billion for the Federal Employee Retirement System, and $355 million for a homeless initiative.

Due to the delay in reaching agreement on the congressional budget resolution for 1988, Congress fell behind schedule with regard to the timetable for action on appropriations measures as well. House action on the 13 regular appropriations measures is supposed to be completed by June 30. By that date in 1987, the House had completed action on only four of the bills. On October 1, the beginning of the new fiscal year, none of the appropriations measures for 1988 was yet enacted. However, 10 of the bills had cleared the House, and the Senate had passed 4. By the end of October, 9 of the 13 appropriation bills for 1988 had passed both Houses and were in, or ready to go into, a joint Senate-House conference.

4. Final Budget Legislation

In late December, following weeks of negotiations, the Congress incorporated the budget summit into two gargantuan budget measures. Passage of this legislation was intended to prove to a jittery Wall Street and American public that Congress could reduce the deficit without relying on the Gramm-Rudman-Hollings measure to kick in and mandate automatic spending cuts. However, before these bills were enacted, it was necessary to pass four short-term continuing resolutions to keep the Federal Government operating.

For the second year in a row, Congress combined all 13 appropriations bill into an omnibus continuing resolution which was signed into law 2000–202 on December 22. The Omnibus Budget Reconciliation Act of 1987 was signed into law on the same day.

The two laws incorporated the compromise provisions, estimated to reduce the deficit by $76 billion over 2 years, that were reached at the budget summit. Of particular note, the reconciliation measure also cancelled the Gramm-Rudman-Hollings sequestration order which had gone into effect on November 20.

D. PROGNOSIS

The 1987 budget summit marked an important watershed for significant Federal actions to reduce the deficit. It arguably was the first year during the Reagan administration that both the Congress and the executive branch actively and successfully worked together toward achieving notable deficit reduction. However, because there are so many unknown variables (including the state of the economy and the degree of partisan bickering during a Presidential election year), it is difficult to determine what the future holds for the budget process and deficit reduction.

Although many Members of Congress, economists, and political analysts were skeptical of the significance of the budget summit and even more skeptical of the potential for substantial cuts in the future, there does appear to be an increasing commitment by both political parties to reduce the Federal deficit. If the Congress and the administration can follow the terms of the 2-year summit agreement, progress can be made not only toward controlling the deficit, but also toward streamlining the budget process.

In January 1988, during his State of the Union Address, the President pledged to refuse to sign any huge conglomeration of budget legislation (as he did with the omnibus reconciliation and appropriations measures) in his final year in office. In addition, he renewed his call for true budget reform. The Congress, also weary of late night sessions in December and thousand-page bills, appears to be ready to work toward reforming the budget process.

Cooperation between the Congress and the President, however, historically has never been a given and, because 1988 is a Presidential election year, there is little doubt that there will be partisan disputes about budget priorities and the budget process. In early 1988, there already had been some disagreement over what was and was not included in the 2-year budget deal. However, even if an agreement on reducing the deficit cannot be reached, the revitalized Gramm-Rudman-Hollings budget cutting measure looms in the background ready to make its across-the-board cuts. With these unknown variables in mind, aging advocates will continue to closely monitor congressional budget activity on programs affecting the elderly during 1988.

SUPPLEMENTAL MATERIAL

Supplement 1

1987 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

Catastrophic Health Care Costs, Washington, DC, January 26, 1987, Hon. John Melcher, Chairman, Presiding

WITNESSES

Joan Yelineck, Beaver Dam, WI.
Edith Rieger, Alva, OK.
Helen Fish, Newport, MI.
Robert Shapland, vice president and actuary, Mutual of Omaha Insurance Co., on behalf of the Health Insurance Association of America.

ISSUES RAISED AND TESTIMONY SUMMARY

Chairman Melcher's primary purpose for convening this hearing was twofold: to call attention to the growing national tragedy of catastrophic health care costs; and to emphasize the urgent need for solutions. The hearing followed introduction by Chairman Melcher and Senator Kennedy of S. 210 to provide catastrophic health care coverage for the elderly and disabled.

Testimony focused on the limited coverage of Medicare and Medicaid as well as "medigap" policies offered by private health insurance carriers. It also underscored the public's lack of understanding of what health care services public and private insurance does and does not cover. Chairman Melcher emphasized the need for major revisions in these health care systems. Limitations in these programs have resulted in the elderly paying out of their own pockets for 25 percent of their health care costs, $30 billion annually, with 42 percent of these expenditures going for nursing home care. According to researchers, elders are spending at least as much of their income on health care today than they spend prior to Medicare.

Testimony of witnesses underscored the fact that catastrophic health care costs can be devastating to the 20 percent of older Americans who have only Medicare coverage and, due to eligibility requirements, only 25 percent of the poor and near-poor elderly are covered by Medicaid. Recent studies show that one-third of elderly households would be financially ruined if one family member were to spend 13 weeks in a nursing home.

Mrs. Joan Yelineck of Beaver Dam, WI described how she and her husband, Donald, lost their home and life savings due to catastrophic health care costs. Mrs. Yelineck said she and her husband were confident that they had sufficient coverage with Medicare and medigap insurance, until they were faced with catastrophic health care costs.

Sixty-seven year old Mrs. Edith Rieger of Alva, OK, testified about her need to work as a cook six days a week at a private club in order to pay for her 83 year old husband's medical and nursing home care. Mrs. Rieger stated, however, that her income work and Social Security income is not enough to keep pace with the costs of their doctor's, hospital's, and prescription drug coverage. Mrs. Rieger is in need of knee surgery, but has put it off and is denying herself medicine because she cannot afford it.

Mrs. Helen Fish of Newport, MI, testified about how medical and nursing bills had eaten up all but $4,000 of her 97 year old mother's life savings of $40,000. Mrs. Fish, who suffers from a heart condition, cares for her mother at home. She urged the Committee to provide some assistance in home health care services for eldery patients like her mother. She pointed out that home health care assistance would cost less than resorting to a nursing home.

Robert Shapland, vice president of the Mutual of Omaha Insurance Company, testified on behalf of the Health Insurance Association of America. Mr. Shapland stated that there indeed are problems in the health care system, especially in educating the public on limitations of coverage in Medicare. He contended, however, that the insurance industry had been very active in educating the public on Medicare coverage and on supplemental coverage provided by medigap policies.

JOINT SENATE SPECIAL AND HOUSE SELECT COMMITTEE ON AGING HEARING—CATASTROPHIC HEALTH COSTS: BROAD PROBLEM DEMANDING EQUALLY BROAD SOLUTION, WASHINGTON, DC, JANUARY 28, 1987, HON. JOHN MELCHER AND HON. EDWARD ROYBAL, CO-CHAIRMEN, PRESIDING

WITNESS

Otis Bowen, M.D., Secretary of the Department of the Health and Human Services.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of the hearing was to explore the multi-generational issues of catastrophic health coverage, to examine the findings and recommendations of Secretary Bowen's catastrophic report, to determine what the final Administration catastrophic proposal would be, and to assess whether the types of approaches that likely would emerge from the President's eventual proposal would be adequate to meet the catastrophic health care needs of all Americans.

Secretary Otis Bowen, appearing as the hearing's sole witness, outlined his recommendations to address the catastrophic protection shortcomings of three vulnerable groups: the elderly who face large out-of-pocket costs associated with lengthy, non-Medicare covered hospital stays for acute illnesses; older Americans who require long-term care; and the 37 million persons under the age of 65 who have no insurance.

To address the Medicare lack of coverage for long-term hospital stays, Secretary Bowen discussed his widely heralded recommendation to include a beneficiary-financed, actuarily sound, acute care catastrophic benefit. This benefit would be financed by a additional catastrophic premium of $4.92 per month that every Medicare beneficiary would pay. Secretary Bowen's proposal to address both the long-term care issue and the under-65 uninsured population relied, to a great extent, on private sector and State initiatives.

While praising Secretary Bowen's report as one that provided an excellent analysis of the scope of the catastrophic problem, Chairman Melcher (as well as many other Members of both committees) raised serious reservations about the report's recommendations. He particularly criticized the proposals to address the elderly's most expensive catastrophic cost—long-term care.

THE PROPOSED FISCAL YEAR 1988 BUDGET: WHAT IT MEANS FOR OLDER AMERICANS, WASHINGTON, DC, MARCH 13, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

William L. Roper, M.D., Administrator, Health Care Financing Administration.

James B. Wyngaarden, Director, National Institutes of Health, accompanied by T. Franklin Williams, Director, National Institute on Aging.

Carolyn Gray, Acting Deputy Assistant Secretary for Human Development Services, Office of Human Development Services, accompanied by Carol Fraser Fisk, Commissioner, Administration on Aging.

Nelson Sabatini, Deputy Commissioner, Management Assessments, Social Security Administration.

Eugene Lehrmann, American Association of Retired Persons.

Jacob Clayman, president, National Council of Senior Citizens.

ISSUES RAISED AND TESTIMONY SUMMARY

Chairman Melcher called this hearing to examine the Administration's fiscal year 1988 budget proposal and how it would affect older Americans. Prior to the hearing, both the Chairman and Senator Heinz released staff reports on the President's budget. Both reports raised significant concerns about the impact budget cuts would have on older Americans.

Dr. William Roper, Administrator of the Health Care Financing Administration, testified that the Administration believed that the proposed cuts in the Medicare and Medicaid programs were minimal. Senator Melcher and many other Members of the committee expressed serious disagreement with Dr. Roper. Opposition was expressed to many of the $5.1 billion in Medicare cuts that were contained in the President's budget, particularly those which would increase costs for beneficiaries. These included a one month delay in Medicare coverage following the 65th birthday; an increase in the Part B premium in 1988, which affects new Medicare beneficiaries;

and Medicaid cuts of $1.3 billion in fiscal year 1988, which would require states or counties to pick up additional costs, or would create further restrictions to needed medical care.

Another area of stated concern was the President's proposal to significantly reduce the Federal commitment to federally-sponsored biomedical research by funding 700 fewer research grants than Congress had originally supported. This would significantly affect the National Institute on Aging research programs.

The committee was also critical of the Administration's proposed cut of 17,000 staff members of the Social Security Administration by 1990. Although the Administration stated that the modernizing of computers and administrative procedures will improve the service, evidence was presented that intimated that, during the process of modernization, the quality of service has suffered.

The President's proposal to virtually eliminate all federal housing programs that build or rehabilitate housing for low and moderate income people, including the elderly, and replace them with rental vouchers was questioned. The committee believes it is unsound financial policy to not maintain the housing stock in which the government has already invested millions of dollars.

The budget request for a generic appropriation of $2.2 billion for the 26 separate social service activities administered by the Office of Human Development Services, including most Older Americans Act programs was another area of concern. This funding approach, it was felt, would leave many aging and non-aging programs unprotected.

THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE, BIRMINGHAM, AL, APRIL 16, 1987, HON. RICHARD SHELBY, PRESIDING

WITNESSES

William F. Bridges, M.D. dean, School of Public Health, University of Alabama at Birmingham.

Jim and Geraldine Turner, Pleasant Grove, Alabama.

Kathy Fuller, Birmingham, AL.

Dr. George L. Layton, vice chairman, Alabama State Legislative Committee, American Association of Retired Persons.

Dr. Raymond L. Walter, president, National Association of Retired Federal Employees.

Amelia Heath, executive director, FOCUS on Senior Citizens of Tuscaloosa County, AL.

Barbara Bonfield, executive director, Jefferson County Office of Senior Citizens Activities.

Dr. Allan R. Goldstein, practicing physicial, Birmingham, AL.

Beverly L. Friedlander, social work services manager, St. Vincent's Hospital, Birmingham, AL.

Karen Hermanson, director, Visiting Nurse Association, Birmingham, AL.

ISSUES RAISED AND TESTIMONY SUMMARY

As a new Member of the Senate and the Special Committee on Aging, Senator Shelby had the distinction of chairing the first committee field hearing of the historic 100th Congress. Although a number of hearings on the catastrophic health care issue had been held in Washington, D.C., Chairman Melcher agreed with Senator Shelby that it was important to receive and relay information on this issue outside of Washington.

The purpose of this hearing included: (1) providing information to the general public regarding the shortcomings of current Medicare coverage of catastrophic illness, (2) obtaining information about what services and problems currently exist for seniors on the community level, and (3) determining what requirements for services, research, and education must be met to formulate an effective, responsive catastrophic proposal.

Senator Shelby, and the witnesses who provided testimony, concluded that the Administration's proposal was too limited in scope and that any catastrophic health legislation worthy of its name needs to find ways to help pay for the devastating costs of long-term care. However, cooperation between Federal government, State governments, insurers and medical providers will be required to meet the ever-increasing demand for long-term and community-based care.

HOME CARE: THE AGONY OF INDIFFERENCE, THE ROLE OF THE OLDER AMERICANS ACT IN ASSURING ACCESS TO QUALITY HOME CARE, WASHINGTON, DC, APRIL 27, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

Pearl Tolbert, Minneapolis, MN; accompanied by her daughter, Dr. Sharon Glover.
Mary Summers, Manassas, VA.
Nilda Grudza, Pendell, PA.
Cathy Beard, R.N., Haymarket, VA.
Barbara Hutton, R.N., Three Oaks, MI.
Charles Wells, Washington, DC, Deputy Commissioner on Aging, Administration on Aging.
Louis B. Hays, Baltimore, MD., Associate Administrator for Operations, Health Care Financing Administration.
Donald Nicholson, Washington, DC, Assistant Inspector General, Department of Health and Human Services.
Ann Mootz, Cincinnati, OH, former director, Home Aide Services and United Home Care; for the National Association for Home Care.
Jane Anderson, director, Area V Area Agency on Aging, Anaconda, MT; for the National Association of Area Agencies on Aging.

ISSUES RAISED AND TESTIMONY SUMMARY

The hearing was called to explore the home care industry and evaluate the role of the Older Americans Act in assuring access to quality home care for our nation's elderly. The committee focused on four major problems currently surrounding home care—training and supervision; limited access to services; lack of consumer protection and involvement; and lack of national standards for quality assurance.

Witnesses provided testimony describing their personal experiences as recipients or providers of home care. Witnesses from the Administration and provider organizations also testified.

The Office of the Inspector General (OIG) of the Department of Health and Human Services released the findings of a study which raised concerns about the overall quality of care provided by home-health aides. The report also noted that recruitment, hiring and retention of home health aides due to low pay and limited benefits are major problems.

The committee severely criticized the Health Care Financing Administration for not implementing a 1980 Congressional mandate for a home-health aide training program prior to providing services. Senator Melcher subsequently requested by letter to Otis R. Bowen, M.D., Secretary of Health and Human Services, that he direct HCFA to take immediate action toward promulgating regulations for training programs as required in the Omnibus Reconciliation Act of 1980.

OUTPATIENT HOSPITAL COSTS, ST. PETERSBURG, FL, JUNE 27, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

Robert D. Nelligan, Redington Beach, FL.
Robert Freytag, South Pasadena, FL.
Daniel McMurray, executive director, St. Anthony's Hospital, St. Petersburg, FL.
Peter J. Levin, M.D., chairman, Hospital Cost Containment Board and dean, University of South Florida College of Public Health, Tampa, FL.

ISSUES RAISED AND TESTIMONY RAISED

The hearing was conducted by Chairman Melcher to explore the reasons for escalating hospital costs around the country, particularly outpatient services. Statistics show that while outpatient revenues are increasingly rapidly, inpatient revenues are on a decline due to the effects of cost-containment measures and the trend toward outpatient care.

Two former outpatient surgery patients testified about what they believed were excessive fees the hospital charged for relatively simple surgical procedures. Hearing testimony revealed that Americans are paying increasingly higher amounts for their health care—for a variety of reasons—but are not necessarily getting their money's worth. By the year 2000, Melcher said, Americans will be paying $1.5 trillion per year for health care, possibly 15 percent of the nation's gross national product. In 1986, health care cost $458 billion, 10 percent of the gross national product.

DEVELOPING A CONSUMER PRICE INDEX FOR THE ELDERLY, WASHINGTON, DC, JUNE 29, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

Mrs. Florence Thompson, Fairview, MI.

Mrs. Rose Affayroux, Baltimore, MD.
Mrs. Margaret Fleming, Fork Union, VA.
Dr. Arthur S. Flemming, cochair, Coalition to Protect Social Security.
Dr. Janet L. Norwood, Commissioner, Bureau of Labor Statistics.
Mr. R.T. Bates, chairman, Railway Labor Executives' Association, Committee on Railroad Retirement, accompanied by Mr. James R. Snyder, chairman, Legislative Committee of the RLEA and William G. Mahoney, counsel.
Mrs. Judith Brown, treasurer, American Association of Retired Persons, accompanied by Dr. Kathleen K. School, policy analyst, AARP.
Ms. Judith Park, legislative director, National Association of Retired Federal Employees.
Ms. Martha McSteen, National Committee to Preserve Social Security and Medicare, accompanied by William Lessard, Director of Policy and Research.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was held to give the Administration and various aging advocacy organizations the opportunity to speak to the shortcomings of current Consumer Price Index (CPI) as an inflation indicator for the elderly and to suggest how an accurate CPI for the elderly might be designed. In addition, elderly witnesses testified about the lack of inflationary protection afforded them by their CPI-based cost-of-living adjustments (COLAs) and their resulting lack of confidence in the CPI as a measure of the inflation they face.

The committee, as well as several witnesses, pointed out that the Department of Labor's current CPI for Urban Wage Earners and Clerical Workers (the CPIw), which is used to formulate Social Security COLAs, does not accurately reflect the inflation that the elderly face. It was noted that the CPIw does not sample retired persons, nor does it properly weigh the impact of medical inflation on older persons, or accurately account for the differing purchasing habits of the elderly. Therefore, many believed that a separate CPI for the elderly is needed to determine whether current CPI-based COLA's provide retirees with adequate inflation protection.

Varying opinions as to the necessity of developing a CPI for the elderly, how it should be formulated and the cost and length of time it would take were presented. In addition, several options for addressing the problem were considered: reweight the inflation data the Department of Labor has available; develop a comprehensive index which surveys more elderly persons and the goods and services they purchase; and use the CPI for All Urban Consumers (CPIu), which measures a larger cross-section of the population than the CPIw (including the elderly), to determine COLAs.

Much attention focused on a unanimously approved amendment by Senator Melcher to the Supplemental Appropriations bill which required that the Bureau of Labor Statistics (BLS), the agency which publishes the CPI, develop a separate consumer price index for older Americans and report its findings to Congress within 90 days. BLS Commissioner Janet Norwood testified that her agency could not meet the 90-day reporting requirement outlined in the amendment. (Due to these concerns, the amendment was dropped from the bill by a conference committee.)

Note: Senator Melcher subsequently introduced a similar amendment to the Older Americans Act, the Consumer Price Index for Older Americans, S. 663, allowing BLS a 180-day reporting period and further defining the elderly to be surveyed to include those "retired Americans aged 62 and over." Language was also added requiring that the Secretary of Labor's submission include a timetable, cost estimates, and suggestions for alternative methods to obtain an accurate measure of the inflation affecting older Americans. The Senate also enacted this new amendment by unanimous vote. BLS now must furnish Congress with the study's results by the end of May 1988.

REAUTHORIZATION OF THE OLDER AMERICANS ACT, CASSELBERRY, FL, JULY 2, 1987, HON. LAWTON CHILES, PRESIDING

WITNESSES

Faye Kalteaux, Federation of Senior Citizens Clubs of Seminole County, the "Brown Bag" Program, accompanied by Virginia Salvino.

Bill Henebry, Pre-Legal Guardianship Counseling Program, Senior Activity Programs, Cocoa, FL, accompanied by Dr. Betty Grossman.

Lorraine Surlak, Christian Service Center, Orange County "Respite" Program, accompanied by Virginia Fletcher and Ruth Levin, case manager.

Dick Smith, executive director of the Osceola County Council on Aging.

Beverly Hougland, Osceola County Dental Program, Osceola County Council on Aging, St. Cloud, accompanied by Katherine McGovern.

Joan Lanier, Pinellas Opportunity Council, Chore Services Program, St. Petersburg, FL, accompanied by Emma Zanetti.

Jeanie Williamson, Bay Area Legal Services, Inc., Tampa, FL, accompanied by Hilde Smallwood.

Aleta Findlay, Employment Services Program, Volusia County Council on Aging, Daytona Beach, FL, accompanied by Betty Oakes.

Helen Blue, executive director, Meals on Wheels of Manatee County, IN, accompanied by Mr. and Mrs. Russell Brock.

Bill Regar, chairman, Advisory Council on Aging, East Central Florida Regional Planning Council/Area Agency on Aging, Orlando, FL.

Judy Thames, executive director, Advisory Council on Aging, East Central Florida Regional Planning Council/Area Agency on Aging, Orlando, FL.

Coach Pete Griffin, vice chairman, State of Florida Aging Advisory Council, Tallahassee, FL.

Margaret Lynn Dugger, Aging Program staff director, Department of Health and Rehabilitative Services, State of Florida, Tallahassee, FL.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of the hearing was to give representatives of various aging organizations and programs the opportunity to present their views, community projects and constituency issues pertinent to the upcoming reauthorization of the Older Americans Act.

The rapid growth of the elderly population and accompanying social problems will have significant impact on services authorized and funded under this act. Those services which assist older persons to remain in their own homes, as well as the expected dramatic demand for additional nursing home care for the growing oldest age group are factors which may also affect future planning for the long term care ombudsman programs authorized under the Act.

Witnesses presented testimony describing new innovative programs and projects instituted in their areas under the OAA to assist the elderly in understanding their medications, providing home chore services, home mental health consultations, legal assistance and dental services. As changes to the Act are considered, other issues of concern include: decreases in services provided to minority elderly; and access problems experienced by individuals with special disabilities and illnesses, such as Alzheimers disease, mental retardation or developmental disabilities.

PRESCRIPTION DRUGS AND THE ELDERLY: THE HIGH COST OF GROWING OLD, WASHINGTON, DC, JULY 20, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

Faye Secrist, Front Royal, VA.

Carrie Morris, Troy, VA.

Cleo Lovell, Trussville, AL.

Helene Levens Lipton, associate professor, Division of Clinical Pharmacy, School of Pharmacy, and senior research associate, Institute for Health Policy Studies, School of Medicine, University of California, San Francisco, CA.

John Stallworth, secretary, American Association of Retired Persons, accompanied by Judith Brown, policy analyst.

Walton Francis, director, Division of Policy Analysis and Regulatory Review, Department of Health and Human Services.

Raymond Scalettar, M.D., board member, American Medical Association, accompanied by Bruce Blehart, department of Federal legislation.

John Schlegel, Pharm.D., president, American Pharmaceutical Association.

Robert Allnutt, Executive vice president, Pharmaceutical Manufacturers Association.

ISSUES RAISED AND TESTIMONY SUMMARY

Chairman Melcher conducted this hearing to focus on the financial impact of prescription drug costs on older Americans, and the need for expanded prescription drug coverage under Medicare.

A report prepared for the Committee by the General Accounting Office (GAO) was released at the hearing. The GAO reported to Chairman Melcher that prescription drugs are the largest out-of-pocket health care expense for three out of every four elderly persons. The reported also cited a Public Health Service finding that 15.5 percent of elders requiring prescription drugs say they are unable to pay for their medicines.

Testimony revealed that cost is one of the primary reasons why the elderly fail to purchase their prescriptions. Witnesses testified from personal experience how prescription costs have affected them. Many have had to make difficult choices between buying their prescriptions, or food, or heating their homes. Foregoing prescription medications for such conditions as diabetes and high blood pressure can result in serious illness and costly hospitalizations.

Witnesses who had been victimized by high prescription drug costs testified about how it was impossible for them to take the drugs they needed and still be able to afford other essentials of life. They stated that in many cases, against the advice of their doctors, they had either not bought or had "stretched-out" the drugs that had been prescribed for them.

Walton Francis, Director of the Division of Policy Analysis and Regulatory Review, represented the Department of Health and Human Services. Mr. Francis argued against prescription drugs being included in catastrophic health care cost legislation. He stated that "drug expenses do not usually represent catastrophic costs," and these costs are often picked up by other insurance, such as Medicaid or Medigap policies. He claimed that analyses of the drug proposals under consideration have shown they would be extremely costly to administer, premium increases would be costly to the beneficiaries, and administration of the program would be exceedingly complex.

The American Pharmaceutical Association, favored the inclusion of pharmaceutical services and prescription drug products in federal government health services strategy. Their testimony focused on three major points: (1) patient compliance with treatment and the economic and social factors which influence it; (2) the central importance of pharmaceutical services and prescription drug products in patient care; (3) and the role of the pharmacist in the areas of rational drug use, compliance and therapy monitoring.

The Pharmaceutical Manufacturers Association (PMA), testified in favor of a targeted or means-tested Medicaid-type State-administered program of prescription drug coverage to help people in dire financial need.

Similar to the PMA, the American Medical Association (AMA) supported the inclusion of outpatient prescription drug coverage as part of catastrophic coverage, provided that the benefit be limited to truly catastrophic costs and that premiums be means-related. The AMA vigorously opposes the establishment of a national or State drug formulary or other mechanisms to restrict drug availability.

MEDICARE HOME CARE BENEFIT: ACCESS AND QUALITY, LAKEWOOD, NJ, AUGUST 3, 1987, HON. BILL BRADLEY, PRESIDING

WITNESSES

Evelyn K. Savage, president, Home Health Agency Assembly of New Jersey, and executive director, Visiting Nurse Association of Somerset Hills, NJ.

Joel S., Gross, M.D., medical director, Greenwall Geriatric Program, Monmouth Medical Center, Long Branch, NJ.

Pat Freeman, legislative chair, Monmouth County Chapter, Older Women's League.

Esther C., Abrams, chairwoman, New Jersey State Legislative Committee, American Association of Retired Persons.

Kenneth R. Dolan, executive director, Home Care Council of New Jersey.

Philip H. Pearlman, president, New Jersey Association of Area Agencies on Aging.

Theresa Dietrich, program development specialist, New Jersey Department of Community Affairs, Division on Aging.

Edith Edelson, New Jersey Federation of Senior Citizens, Inc.

Philip Rubenstein, executive director, Ocean County Office on Aging.

ISSUES RAISED AND TESTIMONY SUMMARY

The hearing was held to review the state of home health care services for the elderly in New Jersey, and to determine whether congressional action over the past year adequately assures that the elderly will receive quality home care.

Testimony revealed that as a result of HCFA's actions, the total number of home health visits provided under Medicare has declined dramatically over the past few years. This is occurring at a time when the elderly population is increasing and hospitals, as a result of the incentives under Medicare's Prospective Payment System, are discharging patients to their homes "sicker and quicker."

Many expressed concern about data showing rising denials of home health claims, the government's ineffective monitoring and control of providers; lack of national minimum qualifications for home health aides; and the virtual absence of consumer information with which to select a high quality provider. Witnesses provided support for legislation introduced by Senator Bradley designed to clarify, expand, and improve the quality of Medicare's home health benefit.

HOUSING THE ELDERLY: A BROKEN PROMISE?, RENO, NV, AUGUST 17, 1987, HON. HARRY REID, PRESIDING

WITNESSES

Honorable Bob Miller, Lieutenant Governor, NV.

Geri Kaufman, representative, National Council of Senior Citizens, Reno, NV.

Doris Isaeff, representative, National Council of Senior Citizens, Reno, NV.

Gail Bishop, American Association of Retired Persons, Reno, NV.

Joseph McKnight, chairman and project Director, Seniors Village Project, Carson City, NV.

Elwood Mose, executive director, Nevada Indian Commission, Sparks, NV.

Peggy Bowen, commissioner, Nevada Indian Commission, Sparks, NV.

Gerald Allen, commissioner, Fallon Tribal Housing Authority, Fallon, NV.

Myla C. Florence, administrator, Department of Human Services, Division for Aging Services, Carson City, NV.

Mike Holm, district director, Farmers Home Administration, Fallon, NV.

Suzanne Bailey, deputy director, Housing Development Division, U.S. Department of Housing and Urban Development, San Francisco, CA.

John D. McGraw, executive, Housing Authority of the City of Reno, Reno, NV.

Honorable Gustavo Nunez, councilman, Reno City Council, Reno, NV.

John B. Hester, assistant director, Washoe County Department of Comprehensive Planning, Reno, NV.

Robert Sullivan, executive director, Nevada Rural Housing Authority, Carson City, NV.

Honorable Thomas J. Grady, mayor, Yerington, NV.

Hon. Larry G. Bettis, Mineral County District Attorney, Hawthorne, NV.

Robert Neilson, immediate past president, Builders Association of Northern Nevada, Reno, NV.

Robert Jones, executive director, Builders Association of Northern Nevada, Reno, NV.

ISSUES RAISED AND TESTIMONY SUMMARY

The hearing was held to address the lack of Federal commitment to adequate and affordable housing for the elderly in Nevada. It also served to help provide a comprehensive picture of Nevada's housing strengths and weaknesses, which could aid in developing an effective housing policy for the Nation's older Americans.

According to testimony, the shortage of inexpensive and subsidized units has led to an increase in Nevada's homeless population. Witnesses also expressed their support for lowering the percentage of income the elderly are required to contribute toward their rent in federally-assisted housing from 30 percent to 25 percent.

The Department of Housing and Urban Development's (HUD) Section 8 vouchers were also discussed by various witnesses. According to supporters, it enables voucher holders to exercise a degree of freedom in their choice of housing. Others fear that it often results in tenants paying more for housing than they would under Section 8 certificates.

Representatives from the Indian community objected to the Housing and Urban Development's (HUD's) rule that calls for total payoff of a project before any deeds or titles are allowed to pass to the housing participants and yet, they are responsible for the maintenance.

Representatives from builders associations urged the committee to encourage trade associations and all other organizations that deal with this problem on a day-to-day basis to begin the study and drafting of the Federal housing program, funded through direct subsidies and/or tax incentives, for low-income families and the elderly. Another witness suggested the development of mobile courts designed especially for the elderly as an alternative to offset the building of expensive housing units.

HOUSING THE ELDERLY: A BROKEN PROMISE?, AUGUST 18, 1987, LAS VEGAS, NV, HON. HARRY REID, PRESIDING

WITNESSES

Hon. Richard Bryan, Governor of Nevada.
Congressman James H. Bilbray.
Ron Lurie, Mayor of Las Vegas.
Sam Wunderbaum, chairman, Nevada State Legislative Committee, American Association of Retired Persons.
Lois J. Benton, executive board member, Nevada State Council of Senior Citizens.
Suzanne Ernst, deputy administrator, Nevada Division for Aging Services.
Suzanne Bailey, deputy director, Housing Development Division, San Francisco Regional Office, U.S. Department of Housing and Urban Development.
Gustavo Ramos, Jr., executive director, City of North Las Vegas Housing Authority.
Mary Kincaid, councilperson, North Las Vegas City Council
Arthur D. Sartini, executive director, Housing Authority of the City of Las Vegas.
W.F. Cottrell, executive director, Housing Authority of Clark County, Las Vegas, NV.

ISSUES RAISED AND TESTIMONY SUMMARY

This was the second of two Nevada field hearings held to address the lack of adequate and affordable housing for the elderly in Nevada.

Witnesses voiced their concern over the drastic cuts in federal funding for elderly housing programs. For example, Community Development Block Grant Programs, which give local and state agencies the opportunity to perform programs and provide benefits to people within the city through revenue sharing, have been severely curtailed due to cuts in federal assistance.

Witnesses stressed the need for setting priorities and suggested various cuts in the defense budget to help fund needed housing and medical care for the seniors. Representatives from AARP made several suggestions that would begin to solve the housing crisis, including the requirement that at least 12,000 new units of Section 202 housing be constructed each year.

PRESCRIPTION DRUG COSTS: THE GROWING BURDEN FOR OLDER AMERICANS, LITTLE ROCK, AR, AUGUST 27, 1987, HON. DAVID PRYOR, PRESIDING

WITNESSES

Loy Cannon, Heber Springs, AR.

Floyd Sexton, Texarkana AR.

Gerald Martinka, director, Pharmacy & Central Sterile Supply, University Hospital of Arkansas; chairman, Medicaid Formulary Committee State of Arkansas.

Bill Groves, pharmacist, Pine Bluff, AR: member, Medicaid Forumlary Committee State of Arkansas.

C. Cecil Fuselier, M. Sc., FASCP, Clinical Pharmacist (Geriatrics) Associate Professor, Department of Pharmacy, University of Arkansas for Medical Sciences.

ISSUES RAISED AND TESTIMONY SUMMARY

The purpose of the hearing was to evaluate the reasons for the escalating costs of prescription drugs, focusing on the effect of rising drug costs on the elderly. It was noted that the American Association of Retired Persons cites cost of prescription medications as the second most important reason elderly people do not fill prescriptions.

The elderly "victim" witnesses testified of their experience of being unable to fill needed prescriptions or go to the doctor because of rising costs. Testimony also focused on those individuals whose incomes are just above the eligibility level for Medicaid, but who are too poor to afford any type of supplemental medical insurance, resulting in high out-of-pocket costs.

Other witnesses discussed the reasons for the cost increases of prescription drugs. Included among them was the cost of the ingredients of the drugs, the manufacturers attempts to recoup research costs through high retail prices, and the lack of competition which results from patent protection. Testimony was also provided concerning problems in drug utilization such as under-use, over-use, combined effects of prescriptions and over-the-counter medications, plus the importance of professional training and consumer education.

TWENTY YEARS OF THE AGE DISCRIMINATION IN EMPLOYMENT ACT: SUCCESS OR FAILURE?, WASHINGTON, DC, SEPTEMBER 10, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

Jules Lusardi, former employee, Xerox Corporation.

Professor Georgiana Jungels, associate professor, State University of New York.

Ronald Hallas, former steel company employee.

Dr. Kermit Phelps, chairman of the board, American Association of Retired Persons.

Burton Fretz, Esq., executive director, National Senior Citizens Law Center.

Alice Quinlan, public policy director, Older Women's League.

Clarence Thomas, chairman, Equal Employment Opportunity Commission.

R. Gaull Silberman, vice-chairwoman, Equal Employment Opportunity Commission.

ISSUES RAISED AND TESTIMONY SUMMARY

This hearing was called to examine the effectiveness of the Equal Employment Opportunity Commission (EEOC) in carrying out its obligations under the Age Discrimination in Employment Act (ADEA). It took place as a result of numerous complaints from constituents who have had difficulties after filing age discrimination complaints with the Commission.

Complaints included allegations that EEOC has allowed long delays in complaint processing without taking any substantive action; that many employees in EEOC's charge intake unit are inexperienced and poorly trained; and that staff members have lost charges that were filed. In addition, a recent General Accounting Office report had charged that one EEOC field office has been closing nearly one-third of all charges without a full investigation and some EEOC personnel were instructed to ignore cases that may require extensive investigation.

Concerns were raised regarding a drastic decline in complaints receiving some type of settlement after a charge was filed with the EEOC (32 percent in 1980 to 12.5 percent in 1986), as well as an increasing case backlog. Senator Melcher questioned EEOC Chairman Clarence Thomas about a commission memorandum which stated that over one-third of the cases being forwarded to the Commission for approval for litigation were beyond the ADEA's two year statute of limitations, and that many had also exceeded the three year statute.

It was reported that of all age discrimination complaints filed with EEOC in FY 1986, fewer than one percent resulted in recommendations for litigation. According to EEOC figures, of the 10,886 complaints filed in FY 1987 through August, only three-quarters of one percent resulted in recommendations for litigation.

Several witnesses provided testimony regarding their unsatisfactory personal experiences in dealing with the EEOC. These included a professor who, due to EEOC's inaction, was forced to file suit without a lawyer the day before the statute of limitations ran out on her case. Another witness questioned EEOC's failure to file suit against a large corporation which had terminated and "voluntarily retired" thousands of workers over 40 in a "reduction of force" and replaced them with thousands of additional younger workers. The problem of "multiple jeopardy" discrimination on the basis of age and sex and/or race was also cited.

Representatives from various aging advocacy organizations testified as to EEOC's activities over the past few years, charging that it has failed to fulfill its obligation to protect older workers from employment discrimination and has not only failed to enforce the statute and its own regulations, but has taken steps to diminish the rights of older workers. These comments included allegations regarding EEOC's rulemaking process. Witnesses cited a decision permitting employees to waive their rights under the ADEA without

EEOC supervision, and a decision to continue exempting apprenticeship programs from the provisions of the Act. (A subsequent amendment by Senator Melcher prevents EEOC's "waiver rule" from having effect throughout fiscal year 1988).

Representatives of EEOC defended its record and listed several policy initiatives they asserted advanced the rights of ADEA complainants. These include an enforcement policy which calls for cases that fail conciliation to be presented to the Commission for litigation consideration; a remedies policy calling for a full remedy to be sought in every case where discrimination is found; an investigative compliance policy dealing with uncooperative respondents in investigations; and an appeals policy for charging parties. They also described their comprehensive training program for field investigators.

EXAMINING THE MEDICARE PART B PREMIUM INCREASE, WASHINGTON, DC, NOVEMBER 2, 1987, HON. JOHN MELCHER, CHAIRMAN, PRESIDING

WITNESSES

William Roper, M.D., administrator, Health Care Financing Administration.

Robert Maxwell, vice president, American Association of Retired Persons, accompanied by Stephanie Kennan, legislative representative, AARP.

Eric Shulman, director, Legislative Liaison and Research Department, National Council of Senior Citizens, accompanied by Lucia Di Venere, deputy director, Legislation and Policy.

Risa Lavizzo-Mourey, M.D., faculty, University of Pennsylvania School of Medicine and the Wharton School.

Ed Howard, coordinator of public policy, Villers Advocacy Associates.

P. John Seward, M.D., chairman, American Medical Association Council on Legislation, accompanied by Bruce Blehart, director, Department of Federal Legislation, AMA.

Martha McSteen, senior consultant, National Committee to Preserve Social Security and Medicare.

ISSUES RAISED AND TESTIMONY SUMMARY

In September, 1987, the Health Care Financing Administration announced that Medicare's Supplemental Medical Insurance (SMI), or Part B, monthly premium would be increased in January, 1988, from its current level of $17.90 to $24.80. The hearing was held to examine the reasons for and the impact of the unprecedented 38.5 percent increase, and to find ways to ensure that an increase of this magnitude would not occur again.

Organizations representing the elderly testified that the increase could have a serious impact on many low to moderate income senior citizens and their ability to meet their everyday expenses of food, housing, and medical care. There was concern that some economically vulnerable elderly could be forced to drop their Medicare Part B coverage altogether.

Dr. Roper, of the Health Care Financing Administration, explained that the three factors influencing the increase were:

(1) earlier projections for 1987 expenditures and utilization under Part B were too low;

(2) the Part B program and program expenditures are projected to continue its current rate of growth; and

(3) due to a surplus in the Part B trust fund (i.e., the contingency reserve), the 1986 and 1987 monthly premiums were, in effect, "discounted" as a result of the contingency reserve fund being drawn down.

Dr. Roper believes the best solution to these increases is a greater reliance on capitation plans. These are plans in which a provider contracts with HCFA to provide all covered health care services for a group of beneficiaries at a fixed reimubursement, regardless of the amount of services rendered. According to HCFA, this approach places responsibility on the provider to ensure that only medically necessary services are being delivered. Other options suggested by Dr. Roper were to provide more intensive claims review, the "bundling" of services for reimbursement purposes, and incentives for beneficiaries to use "preferred providers"—those who do not overutilize the system as recognized by HCFA.

The roles of physicans and physicians' services in the premium increase were also discussed. For example, the high percentage of physicians who do not accept Medicare assignment and the question of whether participation of physicians in the Medicare program should be mandated by law were discussed.

JOINT HEARING: SUBCOMMITTEE ON HEALTH AND SENATE SPECIAL COMMITTEE ON AGING—HOME HEALTH DENIALS UNDER MEDICARE, PORTLAND, ME, NOVEMBER 16, 1987, HON. WILLIAM S. COHEN AND HON. GEORGE J. MITCHELL, COCHAIRMEN, PRESIDING

WITNESSES

Charles Alexander, M.D., Ellsworth, ME.

Noella Turcotte, Lewiston, ME.

Christine Gianopoulos, director, Bureau of Maine's Elderly, August, ME.

Louise S. Gamache, clinical director, Kno-Wal-Lin Community Health and Counseling Services, Bangor, ME.

Joseph H. Pickering, Jr., chairman, Home Care Alliance of Maine; executive director, Community Health and Counseling Services, Bangor, ME.

Linda A. Billows, regional director, National Association for Home-Care, Visiting Nurses Association of Greater Salem, Salem, MA.

Jadine O'Brien, corporate relations officer, Blue Cross/Blue Shield of Maine, Region I Fiscal Intermediary for Medicare Home Health Care, Portland, ME.

John D. Kennedy, administrator, Health Care Financing Administrator, Region I, Boston, MA.

ISSUES RAISED AND TESTIMONY SUMMARY

The hearing was called by Senators Cohen and Mitchell to examine the home health benefit under Medicare and determine how well elderly patients are being served under current policies of the Health Care Financing Administration (HCFA).

According to Senator Mitchell, in recent years, HCFA has initiated a series of policy changes that restrict home care benefits by means of increased claim denials and vague eligibility criteria. Last year, the denial rate for Medicare home health care benefits in Maine reached 30 percent—the highest rate of denials in the nation.

Testimony presented emphasized that the Prospective Payment System (PPS) is providing incentives to acute care hospitals to discharge patients to their homes before they are fully recovered. It was pointed out that these incentives have created a greater need for home health care services.

Witnesses shared personal crises they have experienced because they or a family member have been too well to stay in the hospital and not sick enough to qualify for home health care, but yet they are not well enough to care for themselves. This area of non-reimbursement was described by Senator Cohen as being in a "no-care zone".

Home care providers testified concerning the added burden and demand this shift in health care has placed upon their industry, emphasizing the need for additional Medicare coverage and assistance in training and supervision.

Representatives from Blue Cross/Blue Shield and the Administration presented their perspectives concerning the denials of services and the expected cost to the insurance industry.

Supplement 2

COMMITTEE PRINTS AND REPORTS PRINTED BY THE SPECIAL COMMITTEE ON AGING IN 1987

Helping Older Americans to Avoid Overpayment of Income Taxes, committee print, Serial No. 100–A, January 1987.

Publications List, committee print, Serial No. 100–B, February 1987.

Developments In Aging: 1986—Volume 1—Report No. 100-9, February 1987.

Developments in Aging: 1986—Volume 2—Report No. 100-9, February 1987.

Developments in Aging: 1986—Volume 3—Report No. 100-9, February 1987.

The Proposed Fiscal Year 1988 Budget: What It Means for Older Americans, committee staff report, included in The Proposed Fiscal Year 1988 Budget: What It Means for Older Americans, committee hearing report, Serial No. 100–3, March 1987.

Examining the Medicare Part B Program: An Overview of the Issues, committee staff report, included in Examining the Medicare Part B Premium Increase, committee hearing report, Serial No. 100–114, November 1987.

Older Americans Act Amendments of 1987: A Summary of Provisions, committee print, Serial No. 100–C, December 1987.

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Supplement 3

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PUBLICATIONS LIST

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The Special Committee on Aging, under the direction of its Chairman, publishes committee prints, reports, and transcriptions of its hearings each year. These documents are listed chronologically by year, beginning with reports and committee prints, and followed by hearings.

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REPORTS AND COMMITTEE PRINTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.**
Developments in Aging, 1963 and 1964, Report No. 124, March 1965.**
Developments in Aging, 1965, Report No. 1073, March 1966.**
Developments in Aging, 1966, Report No. 169, April 1967.**
Developments in Aging, 1967, Report No. 1098, April 1968.**
Developments in Aging, 1968, Report No. 91-119, April 1969.**
Developments in Aging, 1969, Report No. 91-875, May 1970.**
Developments in Aging, 1970, Report No. 92-46, March 1971.**
Developments in Aging: 1971 and January-March 1972, Report No. 92-784, May 1972.**
Developments in Aging: 1972 and January-March 1973, Report No. 93-147, May 1973.**
Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.**
Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.**
Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.**
Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, June 1976.**
Developments in Aging: 1976—Part 1, Report No. 95-88, April 1977.**
Developments in Aging: 1976—Part 2, Report No. 95-88, April 1977.**
Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.**
Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.**
Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979.**
Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979.**
Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.**
Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980.**
Developments in Aging: 1980—Part 1, Report No. 97-62, May 1981.**
Developments in Aging: 1980—Part 2, Report No. 97-62, May 1981.**
Developments in Aging: 1981—Volume 1, Report No. 97-314, March 1982.**
Developments in Aging: 1981—Volume 2, Report No. 97-314, March 1982.***

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Developments in Aging: 1982—Volume 1, Report No. 98-13, February 1983.**

Developments in Aging: 1982—Volume 2, Report No. 98-13, February 1983.**

Developments in Aging: 1983—Volume 1, Report No. 98-360, February 1984—$13.*

Developments in Aging: 1983—Volume 2, Report No. 98-360, February 1984—$8.

Developments in Aging: 1984—Volume 1, Report No. 99-5, February 1985.—$9.

Developments in Aging: 1984—Volume 2, Report No. 99-5, February 1985—$8.

Developments in Aging: 1985—Volume 1, Report No. 99-242, February 1986.***

Developments in Aging: 1985—Volume 2—Appendixes, Report No. 99-242, February 1986.*

Developments in Aging: 1985—Volume 3—America in Transition: An Aging Society.*

1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.**

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.**

New Population Facts on Older Americans, 1960, committee print, May 1961.**

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 1961.**

Health and Economic Conditions of the American Aged, committee print, June 1961.**

State Action To Implement Medical Programs for the Aged, committee print, June 1961.**

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**

Mental Illness Among Older Americans, committee print, September 1961.**

1962

Comparison of Health Insurance Proposals for Older Persons, 1961-62, committee print, May 1962.**

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 1962.**

Statistics on Older People: Some Current Facts About the Nation's Older People, June 1962.**

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 1962.**

Housing for the Elderly, committee print, August 1962.**

Some Current Facts About the Nation's Older People, October 1962.**

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

1963

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.**

Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print, October 1963.**

1964

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print, July 1964.**

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print, August 1964.**

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.**

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, committee print, October 1964.**

1965

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964, committee print, January 1965.**

Extending Private Pension Coverage, committee print, June 1965.**

Health Insurance and Related Provisions of Public Law 89–97, The Social Security Amendments of 1965, committee print, October 1965.**

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.**

1966

Services to the Elderly on Public Assistance, committee print, March 1966.**

The War on Poverty As It Affects Older Americans, Report No. 1287, June 1966.**

Needs for Services Revealed by Operation Medicare Alert, committee print, October 1966.**

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 1966.**

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print, December 1966.**

1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.**

1969

Economics of Aging: Toward a Full Share in Abundance, committee print, March 1969.**[1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.**[1]

Health Aspects of the Economics of Aging, committee print, July 1969 (revised).**[1]

Social Security for the Aged: International Perspectives, committee print, August 1969.**[1]

Employment Aspects of the Economics of Aging, committee print, December 1969.**[1]

1970

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, committee print, January 1970.**[1]

The Stake of Today's Workers in Retirement Security, committee print, April 1970.**[1]

Legal Problems Affecting Older Americans, committee print, August 1970.**[1]

Income Tax Overpayments by the Elderly, Report No. 91-1464, December 1970.**

Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.**

Economics of Aging: Toward a Full Share in Abundance, Report No. 91-1548, December 1970.**

1971

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.**[1]

The Nation's Stake in the Employment of Middle-Aged and Older Persons, committee print, July 1971.**

The Administration on Aging—Or a Successor?, committee print, October 1971.**

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.**

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92-433, November 1971.**

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92-450, November 1971.**

Advisory Council on the Elderly American Indian, committee print, November 1971.**

Elderly Cubans in Exile, committee print, November 1971.**

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92-505, November 1971.**

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[1] Working paper incorporated as an appendix to the hearing.

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Research and Training in Gerontology, committee print, November 1971.**

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print, November 1971.**

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, Document No. 92-53, December 1971.**

1972

Home Health Services in the United States, committee print, April 1972.**

Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, committee print, May 1972.**

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print, May 1972.**

Action on Aging Legislation in 92d Congress, committee print, October 1972.**

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.**

1973

The Rise and Threatened Fall of Service Programs for the Elderly, committee print, March 1973.**

Housing for the Elderly: A Status Report, committee print, April 1973.**

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973.**

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.**

Economics of Aging: Toward a Full Share in Abundance, index to hearings and report, committee print, July 1973.**

Research on Aging Act, 1973, Report No. 93-299, committee print, July 1973.**

Post-White House Conference on Aging Reports, 1973, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, September 1973.**

Improving the Age Discrimination Law, committee print, September 1973.**

1974

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.**

Protecting Older Americans Against Overpayment of Income Taxes, committee print, February 1974.**

Developments and Trends in State Programs and Services for the Elderly, committee print, November 1974.**

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Nursing Home Care in the United States: Failure in Public Policy:**
  - Introductory Report, Report No. 93-1420, November 1974.
  - Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print, December 1974.
  - Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print, January 1975.
  - Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print, February 1975.
  - Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print, April 1975.
  - Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print, August 1975.
  - Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print, September 1975.
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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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  - Part 2. St. Petersburg, Fla., November 6, 1961.
  - Part 3. Port Charlotte, Fla., November 7, 1961.
  - Part 4. Sarasota, Fla., November 8, 1961.
  - Part 5. Springfield, Mass., November 29, 1961.
  - Part 6. St. Joseph, Mo., December 11, 1961.
  - Part 7. Hannibal, Mo., December 13, 1961.
  - Part 8. Cape Girardeau, Mo., December 15, 1961.
  - Part 9. Daytona Beach, Fla., February 14, 1962.
  - Part 10. Fort Lauderdale, Fla., February 15, 1962.

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  - Part 2. Newark, N.J., October 16, 1961.
  - Part 3. Philadelphia, Pa., October 18, 1961.
  - Part 4. Scranton, Pa., November 14, 1961.
  - Part 5. St. Louis, Mo., December 8, 1961.

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  - Part 2. Trenton, N.J., October 23, 1961.
  - Part 3. Los Angeles, Calif., October 24, 1961.
  - Part 4. Las Vegas, Nev., October 25, 1961.
  - Part 5. Eugene, Oreg., November 8, 1961.
  - Part 6. Pocatello, Idaho, November 13, 1961.
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  - Part 8. Spokane, Wash., November 17, 1961.
  - Part 9. Honolulu, Hawaii, November 27, 1961.
  - Part 10. Lihue, Hawaii, November 29, 1961.
  - Part 11. Wailuku, Hawaii, November 30, 1961.
  - Part 12. Hilo, Hawaii, December 1, 1961.
  - Part 13. Kansas City, Mo., December 6, 1961.

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  - Part 2. Walla Walla, Wash., November 10, 1961.
  - Part 3. Hartford, Conn., November 20, 1961.
  - Part 4. Boston, Mass., December 1, 1961.
  - Part 5. Minneapolis, Minn., December 4, 1961.
  - Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People:**
  - Part 1. Washington, D.C., October 22 and 23, 1962.
  - Part 2. Newark, N.J., October 26, 1962.
  - Part 3. Camden, N.J., October 29, 1962.
  - Part 4. Portland, Oreg., December 3, 1962.

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Relocation of Elderly People—Continued
    Part 5. Los Angeles, Calif., December 5, 1962.
    Part 6. San Francisco, Calif., December 7, 1962.
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    Part 2. Washington, D.C., January 16, 1963.
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    Part 2. Los Angeles, Calif., January 10, 1964.
    Part 3. San Francisco, Calif., January 13, 1964.
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    Part 2. Washington, D.C., March 9, 1964.
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    Part 4A. Washington, D.C., April 6, 1964 (morning).
    Part 4B. Washington, D.C., April 6, 1964 (afternoon).
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    Part 2. Boston, Mass., January 20, 1964.
    Part 3. Providence, R.I., January 21, 1964.
    Part 4. Saginaw, Mich., March 2, 1964.
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    Part 2. Washington, D.C., April 28, 1964.
    Part 3. Washington, D.C., April 29, 1964.
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    Part 4B. Appendix.
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    Part 2. Washington, D.C., May 6, 1964.
    Part 3. Washington, D.C., May 7, 1964.
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    Part 2. Cleveland, Ohio, February 15, 1965.
    Part 3. Los Angeles, Calif., February 17, 1965.
    Part 4. Denver, Colo., February 23, 1965.

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  Part 6. Boston, Mass., August 9, 1965.
  Part 7. Portland, Maine, August 13, 1965.
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  Part 3. Washington, D.C., January 19 and 20, 1966.
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  Part 1. Washington, D.C., January 17 and 18, 1967.
  Part 2. Tampa, Fla., February 3, 1967.
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  Part 2. Ann Arbor, Mich., July 26, 1967.
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  Part 2. Seattle, Wash., October 14, 1968.
  Part 3. Ogden, Utah, October 24, 1968.
  Part 4. Syracuse, N.Y., December 9, 1968.
  Part 5. Atlanta, Ga., December 11, 1968.
  Part 6. Boston, Mass., July 11, 1969.
  Part 7. Washington, D.C., October 14 and 15, 1969.
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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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  Part 1. Los Angeles, Calif., December 17, 1968.
  Part 2. El Paso, Tex., December 18, 1968.
  Part 3. San Antonio, Tex., December 19, 1968.
  Part 4. Washington, D.C., January 14 and 15, 1969.
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  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.
  Part 6. Cape May, N.J., retirement community, August 15, 1969.
  Part 7. Washington, D.C., international perspectives, August 25, 1969.
  Part 8. Washington, D.C., national organizations, October 29, 1969.
  Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.
  Part 10A. Washington, D.C., pension aspects, February 17, 1970.
  Part 10B. Washington, D.C., pension aspects, February 18, 1970.
  Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.
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  Part 1. Washington, D.C., July 30, 1969.
  Part 2. St. Petersburg, Fla., January 9, 1970.
  Part 3. Hartford, Conn., January 15, 1970.
  Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
  Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
  Part 6. San Francisco, Calif., February 12, 1970.
  Part 7. Salt Lake City, Utah, February 13, 1970.
  Part 8. Washington, D.C., May 7, 1970.
  Part 9. Washington, D.C. (Salmonella), August 19, 1970.
  Part 10. Washington, D.C. (Salmonella), December 14, 1970.
  Part 11. Washington, D.C., December 17, 1970.
  Part 12. Chicago, Ill., April 2, 1971.
  Part 13. Chicago, Ill., April 3, 1971.
  Part 14. Washington, D.C., June 15, 1971.
  Part 15. Chicago, Ill., September 14, 1971.
  Part 16. Washington, D.C., September 29, 1971.
  Part 17. Washington, D.C., October 14, 1971.

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- Part 18. Washington, D.C., October 28, 1971.
- Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
- Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
- Part 20. Washington, D.C., August 10, 1972.
- Part 21. Washington, D.C., October 10, 1973.
- Part 22. Washington, D.C., October 11, 1973.
- Part 23. New York, N.Y., January 21, 1975.
- Part 24. New York, N.Y., February 4, 1975.
- Part 25. Washington, D.C., February 19, 1975.
- Part 26. Washington, D.C., December 9, 1975.
- Part 27. New York, N.Y., March 19, 1976.

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- Part 1. Des Moines, Iowa, September 8, 1969.
- Part 2. Majestic-Freeburn, Ky., September 12, 1969.
- Part 3. Fleming, Ky., September 12, 1969.
- Part 4. New Albany, Ind., September 16, 1969.
- Part 5. Greenwood, Miss., October 9, 1969.
- Part 6. Little Rock, Ark., October 10, 1969.
- Part 7. Emmett, Idaho, February 24, 1970.
- Part 8. Boise, Idaho, February 24, 1970.
- Part 9. Washington, D.C., May 26, 1970.
- Part 10. Washington, D.C., June 2, 1970.
- Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
- Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.

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- Part 2. Washington, D.C., June 8 and 9, 1970.

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- Part 1. St. Louis, Mo., August 11, 1970.
- Part 2. Boston, Mass., April 30, 1971.

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- Part 1. Washington, D.C., March 25, 1971.
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- Part 4. Washington, D.C., March 31, 1971.
- Part 5. Washington, D.C., April 27, 1971.
- Part 6. Orlando, Fla., May 10, 1971.
- Part 7. Des Moines, Iowa, May 13, 1971.
- Part 8. Boise, Idaho, May 28, 1971.
- Part 9. Casper, Wyo., August 13, 1971.
- Part 10. Washington, D.C., February 3, 1972.

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- Part 1. Los Angeles, Calif., May 10, 1971.
- Part 2. Woonsocket, R.I., June 14, 1971.
- Part 3. Providence, R.I., September 20, 1971.

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Unemployment Among Older Workers: **
  Part 1. South Bend, Ind., June 4, 1971.
  Part 2. Roanoke, Ala., August 10, 1971.
  Part 3. Miami, Fla., August 11, 1971.
  Part 4. Pocatello, Idaho, August 27, 1971.
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  Part 6. Washington, D.C., July 31, 1972.
  Part 7. Washington, D.C., August 1, 1972.
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  Part 9. Boston, Mass., October 2, 1972.
  Part 10. Trenton, N.J., January 17, 1974.
  Part 11. Atlantic City, N.J., January 18, 1974.
  Part 12. East Orange, N.J., January 19, 1974.
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  Part 5. Washington, D.C., July 26, 1973.
  Part 6. Twin Falls, Idaho, May 16, 1974.
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  Part 12. Washington, D.C., May 1, 1975.
  Part 13. San Francisco, Calif., May 15, 1975.
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  Part 15. Des Moines, Iowa, May 19, 1975.
  Part 16. Newark, N.J., June 30, 1975.
  Part 17. Toms River, N.J., September 8, 1975.
  Part 18. Washington, D.C., October 22, 1975.

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  Part 19. Washington, D.C., October 23, 1975.
  Part 20. Portland, Oreg., November 24, 1975.
  Part 21. Portland, Oreg., November 25, 1975.
  Part 22. Nashville, Tenn., December 6, 1975.
  Part 23. Boston, Mass., December 19, 1975.
  Part 24. Providence, R.I., January 26, 1976.
  Part 25. Memphis, Tenn., February 13, 1976.
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  Part 6. Washington, D.C., July 12, 1973.
  Part 7. Coeur d'Alene, Idaho, August 4, 1973.
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  Part 11. Albuquerque, N. Mex., May 25, 1974.
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  Part 4. Washington, D.C., April 9, 1974.
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  Part 2. Boston, Mass., August 30, 1976.
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  Part 5. Sioux Falls, S. Dak., August 18, 1976.
  Part 6. Rockford, Iowa, August 18, 1976.
  Part 7. Denver, Colo., March 23, 1977.
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  Part 9. Tucson, Ariz., November 7, 1977.
  Part 10. Terre Haute, Ind., November 11, 1977.
  Part 11. Phoenix, Ariz., November 12, 1977.
  Part 12. Roswell, N. Mex., November 18, 1977.
  Part 13. Taos, N. Mex., November 19, 1977.
  Part 14. Albuquerque, N. Mex., November 21, 1977.
  Part 15. Pensacola, Fla., November 21, 1977.
  Part 16. Gainesville, Fla., November 22, 1977.
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- Part 1. Washington, D.C., April 18, 1977.
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- Part 1. Washington, D.C., May 16, 1977.
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- Part 3. Washington, D.C., June 15, 1977.
- Part 4. Cleveland, Ohio, July 6, 1977.
- Part 5. Washington, D.C., September 21, 1977.
- Part 6. Holyoke, Mass., October 12, 1977.
- Part 7. Tallahassee, Fla., November 23, 1977.
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  Part 3. Washington, D.C., December 3, 1980.
  Part 4. Washington, D.C., December 4, 1980.
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